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1. PROGRAM PRIORITIES

The Centers for Disease Control and Prevention (CDC) has established the following priorities for STI programs:

- Surveillance
- MSM populations
- Resistant Gonorrhea
- Congenital syphilis
- Adolescents
- Cross-cutting issues

The Kansas STI/HIV Section has established the following priorities for interviews/intervention*:

1. Syphilis
2. HIV
3. Gonorrhea in Geary, Sedgwick, Shawnee, and Wyandotte Counties

*Chlamydia interviews are not required by the Disease Intervention Program. Behavioral Intervention Specialists (BIS) are permitted to interview chlamydia cases if they feel it is necessary or to assist the local health departments and if other priorities do not suffer as a result.

2. CONFIDENTIALITY

All employees of the STI/HIV Section of KDHE (including contractual employees) are required to sign a confidentiality statement **(BDCP Data Security and Confidentiality Policy for HIV, Viral Hepatitis, Sexually Transmitted Infection, Tuberculosis, and Vaccine-Preventable Disease (Immunization) Programs)** and abide by its requirements**.** This statement must be signed upon initial hire and annually thereafter. This Policy can be found in Appendix 1, and should serve as a minimum requirement for BIS.

- The most important aspect of a Behavioral Intervention Specialist's (BIS) duties is to protect the confidentiality of all persons. Maintaining confidentiality is essential to ensure that clients do not delay treatment or go untreated as a result of concerns about the health department's ability to maintain confidentiality.
- All STI/HIV information must be maintained on a need to know basis. This includes information divulged to personnel at county health offices. If the specific individual does not have the need to know medical information on a patient, the information should not be available to them. (e.g. Immunization nurses not involved in the direct care of a client should not have access to a patient's information sitting on a desk).
- Do not use vehicles with state, county, or health department markings (signs on sides of vehicles, license plates, etc.).
- Do not wear clothing with state, county, or health department logos on them.
- ID badges should not be worn in the field, but should be accessible to show when appropriate.
- Referral letters mailed or left at a home, school, or business should not indicate a specific disease on the referral letter. Phrases such as "you have been in contact with (or reported with) syphilis" are not appropriate.
- When dealing with partners, clusters, and third parties, BIS must be careful not to reveal any identifying information. Identifying information includes exposure dates, place of residence, or any physical characteristics. If questioned by a contact about the individual who named them, the BIS should assure the partner that the information is legitimate and that the original patient was very concerned about them. When in doubt about what to tell someone, PLAY IT SAFE! Do not say or do anything that could jeopardize confidentiality and ultimately, the reputation of the health department and the outcome of future investigations. Discuss the appropriateness of any questionable language or approach with your supervisor before contacting a client.
- E-mail that travels outside the KDHE/county health department firewall is NOT considered secure, since it can be intercepted. Please use the following precautions when sending e-mail messages related to case patients

3. QUALITIES OF EFFECTIVE BIS

BIS within the Kansas STI/HIV Section are expected to demonstrate the following:

Professionalism: BIS are expected to be conscientious, show integrity, and be self-motivated. Telephone calls and other communications are to be returned within 24 hours during workdays. BIS are expected to dress in a manner that is appropriate to ensure accordance with state and/or local guidelines and safety in the field.

Persistence: BIS must be able to motivate patients during interviews, get third parties to discuss the whereabouts of certain persons, and obtain demographic and treatment information from health care providers. Successfully referring a person for a medical evaluation often requires multiple home visits and phone calls.

Nonjudgmental Attitude: Getting people to discuss the most intimate part of their lives is difficult. Your personal feelings should not allow the patient to perceive that you are uncomfortable discussing their sexual behavior.

Effective Listening Skills: Do not allow distractions and interruptions during interviews. A patient will usually communicate problem indicators that must be addressed in the interview and you must be able to recognize them. Paraphrase information that patients give you to show them you understand what they are saying.

Assertiveness: As opposed to passive or aggressive conduct, BIS are expected to tactfully but firmly confront sexual histories (one-time exposures, pickups, and prostitutes) as well as exposure gaps, conflicting information from partners, etc.

Communicate at the Client's Level of Understanding: BIS must avoid the use of complicated language and technical terms, and use visual aids and vernacular when necessary to explain STIs/HIV to patients.

Rapport Building: It is very important for the BIS to build rapport with the clients and providers in order to collect the information necessary to have a successful investigation. Explain to the client how cooperating with you benefits them. Maintain a calm manner at all times.

Critical/Analytical Thinking: BIS must be able to critically analyze information about investigations to determine conflicts in information, exposure gaps, transmission gaps, etc. This information must be able to be analyzed by the BIS while they are conducting an interview.

4. EXPECTATIONS

A. **Interviewing and Counseling:** The success or failure of intervention by BIS is judged as much by the quality of the process as by the intervention results. Each activity performed by BIS is expected to receive the best effort of which the worker is capable in preparation and execution.

1. **Interview Preparation-BIS will perform the following in preparation of each interview:**
   - Review all pertinent medical records
   - Determine the reason for initial exam
   - Review current and past STI epidemiological information (Search local medical records and TriSano)
   - BIS must be prepared to find clients and perform syphilis/HIV interviews as soon as possible. Delaying these actions may result in the BIS being unable to locate the patient or decreased efficacy during the interview.

2. **Interviews-BIS will perform the following during each interview:**
   - Conduct all syphilis and HIV interviews (including re-interviews and cluster interviews) in person unless prior arrangements have been made with the Section Chief or Disease Intervention Program Manager.
   - Maintain professionalism
   - Emphasize confidentiality and discretion
   - Convey a sense of urgency
   - Establish rapport with the patient
   - Listen and assess the patient's needs
   - Use open-ended questions
   - Communicate at the patient's level of understanding
   - Deliver disease and patient-specific behavioral messages
   - Establish specific contracts with patients who choose to refer their sexual partners in for treatment themselves. The BIS should still assume responsibility for partner referral in these instances, and continue to be proactive in performing intervention activities.
   - Recognize and respond to problem indicators
   - Confront evasive answers and resistance firmly
   - Persist tactfully to elicit all sexual partners
   - Persist tactfully to elicit all social contacts
   - Pursue all information, as detailed as possible, for identifying and locating each sexual partner/cluster.
   - Pursue information on male, female, and transgendered sexual contacts.

3. **Interview Documentation:**
   - The required documentation for each interview (i.e. Interview Record, narrative write-up, re-interview, cluster, etc.) must be completed within 24 hours (or 1 business day, whichever is longer). In no case will submission into TriSano exceed 24 hours (1 business day) after the completion of the activity without

prior approval from the STI/HIV Section Chief or Disease Intervention Program Manager.
- All case documentation will be continually updated with current information (tests, interviews, locating, etc.)

4. **Investigations:**
   - All BIS are responsible for communication with the providers, labs, community based organization, and all other entities located within their assigned area. This responsibility cannot be delegated or transferred to BIS outside of the area without prior approval from the Section Chief or Disease Intervention Program Manager. If a provider needs to be contacted that is outside of your assigned area, you must call the BIS in the area where the provider is located, and that BIS is responsible for contacting the provider and relaying all pertinent information to you.
   - CMRs must be accepted within one working day.
   - Within 24 hours of receiving a CMR (Case Morbidity Record or field record), the BIS must perform, at a minimum, one investigative activity.
   - Intervals between actions on any investigation shall not exceed two workdays for gonorrhea, and 1 day for syphilis and HIV without prior approval from the STI/HIV Section Chief or Disease Intervention Program Manager.
   - Investigative activities must be immediately and fully documented in each CMR.
   - Field screening must be offered when clinical testing is unavailable or impractical to perform. BIS must be prepared to draw field bloods at all times, including those when a field blood has not been anticipated or scheduled. **All field testing will be performed exclusively for public health investigation purposes.**
   - Mailed letters are NOT a substitute for field visits or phone calls, and will be utilized only in conjunction with field visits, phone calls, e-mails, and text messages.
   - Multiple field and phone attempts to locate must be made during different times of the day/night.
   - When notifying sexual partners and/or clusters, BIS must not imply that they are infected, but rather explain that they have been exposed or are at risk.

B. Provider Visits: BIS are expected to maintain relationships with their assigned providers at a level adequate to ensure continued access to patients and patient information. To assist in this expectation, all BIS are required to perform and document a minimum of 50 provider visits annually to provide technical assistance and program visibility to selected providers. The providers should be selected from one of the following priority areas; MSM, resistant gonorrhea (MDs that see a high number of gonorrhea cases), heterosexual syphilis (MDs that have found early syphilis cases in females) and adolescents. All visits should be documented on the Provider Visitation Form which can be found at the BIS Portal at http://www.kdheks.gov/sti_hiv/ and submitted via e-mail to Central Office within fourteen (14) days from the end of each month.

C. Timeliness of Work:

- BIS will conduct an intensive disease intervention interview on at least 75 percent of all cases of gonorrhea within seven days of initiation to the field.
- BIS will conduct and intensive disease intervention interview on 95 percent of gonorrhea cases with possible treatment failure or suspected cephalosporin resistance.
- BIS will conduct an intensive disease intervention interview on at least 90 percent of all cases of syphilis within seven days of initiation to the field.
- BIS will conduct an intensive disease interview on at least 70 percent of all assigned HIV cases within seven days of initiation to the field.
- BIS will ensure the examination of at least 75 percent of all new, locatable, in jurisdiction sexual partners of gonorrhea cases within seven days from the date of initiation.
- BIS will ensure the examination of at least 70 percent of all new, locatable, in jurisdiction sexual partners of syphilis cases within seven days from the date of initiation.
- BIS will obtain a final disposition on at least 80 percent of all gonorrhea reactors within seven days of initiation to the field.
- BIS will obtain a final disposition on at least 80 percent of all early syphilis reactors within seven days of initiation to the field.
- BIS will obtain a final disposition on at least 80 percent of all assigned HIV cases within seven days of initiation to the field.

D. Productivity of Work:

- BIS will initiate at least 1.0 sexual partners per case of gonorrhea interviewed.
- BIS will initiate at least 2.0 sexual partners per case of syphilis interviewed.
- BIS will initiate at least 1.0 cluster suspects or associates per case of early syphilis interviewed.
- BIS will conduct at least one intensive disease intervention re-interview on 90 percent of all early syphilis cases during the course of the investigation.
- BIS will initiate at least 2.0 sexual and/or needle-sharing partners per case of HIV interviewed.
- BIS will initiate at least 1.0 cluster suspects or associates per case of HIV interviewed.

E. Delinquent CMRs:

CMRs that are open longer than two weeks past the date that the CMR is assigned to the specific BIS are considered delinquent. Each month, BIS will meet with their direct supervisor and go over their delinquent CMRs. If the CMR is still open and needs to remain open, the BIS or the lead BIS will need to contact the Section Chief or Program Manager for approval.

5. EVALUATION

Overall BIS performance is typically evaluated twelve times per calendar year (one time per month) through CMR, field, and interview audits. The result of these audits will be compiled for BIS annual evaluation. Copies of the audit forms can be found at the BIS Portal at http://www.kdheks.gov/sti_hiv. These audits assess the ability of the BIS to complete assignments in an accurate, timely and effective manner, along with the ability to follow required procedures and guidelines.

Also considered is the ability of the BIS to:

- Act in response to internal and external stakeholders,
- Develop and maintain effective relationships,
- Respond to inquiries and circumstances as necessary
- Adapt to stressful situations,
- Proficiency and accuracy of written and verbal communication
- Actively seek out new solutions, tasks, opportunities or development that improve the organization's ability to accomplish its mission in a more effective and efficient manner

6. HEALTH RECOMMENDATIONS

It is required that all BIS be read and abide by the KDHE Blood Borne Pathogen Exposure Control Plan (ECP). The ECP specifies that all BIS **must** be offered the Hepatitis B vaccination series. All BIS are required to complete the "Hepatitis B Vaccination & Post-Vaccination Serologic Testing Form". This form documents that the BIS has received information concerning the risk of occupational exposure to blood or other potentially infectious materials in their position. The BIS will document whether they received the vaccination and the need for follow-up testing, or whether they decline to receive the series. A copy of this signed form will be kept in the central office of the STI/HIV Section and in their confidential personnel file in HR.

It is further required that BIS receive annual influenza vaccinations and Tuberculosis quantiferon testing, or sign a declination.

7. BIS TRAINING REQUIREMENTS

A. Passport to Partner Services Online (PPSO):

Completion of the PPSO is required within thirty (30) days from the date of hire and prior to any investigative activities being performed by new BIS. The Passport to Partner Services training program was created by the Centers for Disease Control and Prevention (CDC) to provide information on STIs, including HIV and Hepatitis, guidance on field work and investigation, and to assist BIS in providing guidance to providers on syphilis diagnoses.

B. Passport to Partner Services:

Completion of this three day, in-person course is required within six (6) months of hire date. This CDC course is specifically designed for Behavioral Intervention Specialist (BIS), and emphasizes the development of skills and techniques for interviewing STI/HIV clients in order to identify sex and needle-sharing partners. This course also focuses on how to help clients manage current infection and reduce risks for future infections. Participants practice communication, problem solving, and motivation skills in role-plays, and receive feedback from the instructor. The course includes an introduction to visual case analysis for syphilis, case management, and the Lot System. Prior to attending this course, participants will need to successfully complete the CDC PPSO.

C. BIS Clinic/Lab Training
(KSTrain Course ID: 1054485):

BIS are required to perform 40 hours of clinical shadowing within 90 days of hire. Clinical training includes chart reviews, phone calls, lab tours, clinic-specific orientation,and data management. Additionally, all newly hired BIS are required to spend 24 hours in central office to receive training on the TriSano case management system.

D. BIS Field Visit Training
(KS Train Course ID: 1053215)

BIS are required to perform a minimum of ten (10) field visits with an audit score of 3.0 or greater within 90 days of hire. Field Visit training includes observing and being observed for field visits, BIS-delivered therapy, and provider visits.

E. BIS Interview Training
(KS Train Course ID: 1055762)
BIS are required to observe at least ten (10) interviews, perform ten (10) mock interviews, and conduct a minimum of ten (10) interviews with an audit score of 3.0 or greater.

F. HIV – Introduction to HIV/AIDS
(KSTrain Course ID: 1023485):
Completion of this course is required within six (6) months of hire date. Subject areas of this web-based KDHE course include: cultural competence, Infectious Diseases/Immunizations, STI, and HIV/AIDS.

G. HIV Testing Annual Update
KDHE provides an annual update course related to HIV Counseling & Testing. The content of this course varies each year, and completion of this course is required annually.

H. STI/HIV Section-Disease Intervention Quarterly Staff Meetings
(KSTrain Course ID: 1053218):
STI/HIV Disease Intervention Program Staff Meetings are held on a quarterly basis as a forum to provide updated information to all field staff on current issues. **Attendance at staff meetings is mandatory for all BIS (including contractual BIS).** The only acceptable absences from a staff meeting include: time off approved prior to the announcement of the staff meeting date and employees eligible on leave under FMLA (Family Medical Leave Act) or prior, written approval from the Section Chief or Program Manager.

I. KDHE: Bloodborne Pathogen Training – Web-based
(KSTrain Course ID: 1021712):
Bloodborne Pathogen Training must be completed within ninety (90) days from the date of hire and prior to performing any job duties with potential exposure to blood or other potential infectious materials (OPIM). The training discusses KDHE's bloodborne pathogen exposure control plan, universal precautions, work practice controls, personal protective equipment, labeling and signs, vaccines, and exposure incidents.

J. KDHE: BDCP – Security and Confidentiality Training
(KSTrain Course ID: 1050300):
All employees of the Bureau of Disease Control and Prevention (BDCP) are required to complete training within thirty (30) days of hire and annually thereafter. Training includes instruction on the appropriate handling of confidential information, physical security, and steps to take if a breach occurs.

K. KHEL: New Universal Sample Submission Form Overview-ONLINE
KSTrain Course ID: 1047090):
All BIS must complete this training within six (6) months of hire. Training provides an overview of how to complete the KHEL Universal Sample Submission Form.

L. STI/HIV Venipuncture Training

(KSTrain Course ID: 1047031):

All BIS must complete venipuncture training within ninety (90) days from the date of hire and prior to performing any type of venipuncture. This training is provided by the STI/HIV Section and consists of a one-half day of coursework to introduce the participant to the concepts, skills, and techniques required for venipuncture. The course includes skill building through the use of an artificial arm. Follow-up requirements consist of clinical practice to successfully perform venipuncture a minimum of six times.

All field testing will be performed exclusively for public health investigation purposes.

M. Training/Meeting Etiquette

The following etiquette should be observed during all trainings and staff meetings:

- All newspapers, magazines, and other reading material not related to the meeting must be put away during the meeting.
- The speaker should be the only one talking.
- All responses during presentations should be professional and motivated by the presentation.
- All electronic equipment (cell phones, blackberries, computers, etc) must be put away during the meeting unless given specific permission from the Section Chief or Program Manager.
- Take responsibility for staying "tuned in" with the presentation.
- All staff should be in their seats when presentations are scheduled to begin.
- Meals should not be brought in to the meeting.

8. HIPAA-HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

HIPAA is a law that was designed to protect persons from unauthorized disclosure of personal health information. HIPAA specifies that covered entities MUST comply with state laws.

Kansas Statute (K.S.A. 65-118) details the legal responsibility of mandated reporters (including laboratories, physicians, physician's assistants, licensed nurses, licensed practical nurses, social worker, hospitals, clinics, or other private or public institutions providing diagnostic testing, screening or care to any person with any disease, condition or finding) included on the list of Reportable Diseases and Conditions.

BIS (including contractual BIS), as agents of the Kansas Department of Health and Environment, are allowed to receive protected health information if it is requested during the course of an investigation on a need-to-know basis. Occasionally, during an investigation, an entity is encountered who is hesitant to provide client information to a BIS based on the HIPAA protections of patients' rights to privacy. KDHE approved letters that can be utilized for the purpose of explaining the law and the exceptions allowable under the law can be found in the BIS portal at http://www.kdheks.gov/sti_hiv.

In addition, CDC offers sample correspondence to assure providers that they are protected when they release the requested information to the BIS. For CDC examples, please visit http://www.cdc.gov/privacyrule/Guidance/AppendixB.htm.

9. GENERAL INVESTIGATION REQUIREMENTS

A. Minimum Investigative Requirements

- Activities must be initiated within 24 hours of receipt of the CMR.
- Gonorrhea reactors and contacts within your priority counties must receive phone calls at 3 different times, 2 field visits to the patients address, a text message (if a cell phone number is provided), and a mailed referral.
- Phone calls should be the principle intervention activity to reach Gonorrhea reactors and their contacts.
- For syphilis and HIV cases and their contacts BIS must attempt multiple FVs (minimum 10) and phone calls (minimum 20) to contact the patient. Before closing as "unable to locate" BIS must contact the Central Office to perform a Lexis Nexis search. The Section Chief or Program Manager must approve an "unable to locate" case.
- Documentation in TriSano of all investigative activities (including interviews) must be completed in accordance with guidance provided in the TriSano STI/HIV Section User Guide.
- When attempting to locate a school aged child, BIS are expected to talk to the local health department to obtain the name of the school nurse (if it is not already known to the BIS), and work through the nurse to locate the student.
- For a listing of potential resources to locate clients, please see **Appendix 4**-BIS Investigative Resources.

B. Interview Requirements

- All interviews must be documented in the CMR within 24 hours of the event.
- All early syphilis and new HIV cases must be interviewed in person.
- BIS must attempt to interview all priority gonorrhea cases as defined by program management.
- Case Morbidity Reports (CMR) can be closed when all interviews, re-interviews, and cluster interviews have been performed and entered; and all contacts and clusters have been properly closed. Gonorrhea interviews should be closed within fourteen (14) days of initiation. Syphilis and HIV Interviews should be closed within two (2) months of initiation. Any exceptions to these deadlines must be approved by the Section Chief or Disease Intervention Program Manager.
- All early syphilis cases are required to receive a re-interview within one week of the original interview. The re-interview must be arranged, time and place, before the original interview is terminated. The time and place arranged for the re-interview must be documented on the Original Interview in TriSano. The re-interview must be entered into TriSano within 24 hours (1 business day) of the interview.
- All sexual contacts to early syphilis and new HIV cases are required to receive a cluster interview. The cluster interview must be entered in TriSano within 24 hours (1 business day).

C. Venipuncture

All BIS will be trained to perform venipuncture. BIS must obtain field bloods as necessary to complete investigative activities. Blood kits must be packed, organized, and for ready use. BIS must be prepared to draw field bloods ANY time they leave their clinical setting. BIS must read and abide by the KDHE Bloodborne Pathogen Exposure Control Plan (Appendix 2)

and/or county or local requirements as appropriate. **All field testing will be performed exclusively for public health investigation purposes.**

Authority to perform field blood testing:
K.S.A 65-101 (a) (5) allows the Secretary of the Kansas Department of Health and Environment to take action to prevent the spread of infectious or contagious diseases within the state. K.S.A. 65-202 requires a local health officer to make an investigation of infectious and contagious diseases and to use all known measures to prevent the spread of such diseases. K.A.R. 28-1-5 contemplates the power to obtain specimens for laboratory evidence of infectious or contagious diseases. The authority in these statutes and regulation enables KDHE or local health departments to use whatever means as are reasonable to investigate and prevent the spread of infectious diseases, including the use of field blood tests.

D. Field Safety

BIS are encouraged to use common sense and safety measures when performing fieldwork. Checking into the Central Office by 8:30 in the morning and alerting the Central Office when you leave your area are **required** safety measures. BIS should follow CDC recommendations for safety in the field. Discuss any potentially unsafe situations with your supervisor and, if indicated, leave the addresses of your visits with a coworker or your supervisor.

E. Work Related Injuries

State employees injured on the job need to immediately notify the STI/HIV Section Chief and/or the Disease Intervention Program Manager (even if you are stationed at a county health department) for guidance. If it is after hours, and you are unable to speak directly to your state supervisor, leave your supervisor a message with all pertinent information, and proceed to the nearest emergency room for evaluation. Consult with your supervisor the next working day to begin workman's compensation proceedings.

County employees need to consult with county supervisors to determine county-specific workers compensation policies.

F. **Field Work Documentation :** "If it isn't documented, it didn't happen."
All documentation must be complete, accurate and current. CMR documentation must contain the time and date for each action, and the names of persons with whom you speak. It **is** appropriate to document subjective comments on the direction and/or accurateness of investigations and/or investigative information. Please refrain from writing judgmental statements about clients, other BIS, or providers. Use actual quotes of conversation when possible. All documentation is due within 24 hours of return to your work station.

G. Referral Notes, E-mails, and Text Messages

Standardized wording has been developed for use by all BIS to ensure consistency and confidentiality. BIS may add urgent or personal messages to the wording as long as they do not divulge the reason for the person being contacted. Notes should be in sealed envelopes with only the client's name and address (when appropriate) on the outside. The "contact information" should include the BIS's name, phone number, clinic address, and e-mail address.

Standardized referral letter wording:

Dear _____ Date _____

There is an urgent health matter that requires your immediate attention. Please call me at _____ as soon as possible.

(Contact Information)

E-mail and Text Messages

E-mails and text messages should be used as needed. The subject line of e-mails should read "Important Health Matter." BIS are encouraged to send patients and contacts text messages as soon as a cell phone is identified.

The following standard message should be used for both e-mail and text messages:

There is an urgent health matter that requires your immediate attention! Please call me at _____ as soon as possible!

- ✓ No disease, personal identifying information, or exposure information is to be given over texts or e-mails.
- ✓ Texts and e-mail are intended to motive the patient to call.

If a patient replies to an e-mail or text message requesting additional information the BIS needs to explain that they are not allowed to discuss personal health information over e-mail/text and that the patient needs to call to receive the information.

H. Out of State Cases/Contacts:

All CMRs that need to be sent to an out-of-state jurisdiction need to be routed to the STI/HIV Research Analyst. In addition, please send the STI/HIV Research Analyst a task alerting them to the case.

I. Field Work Organization

Prior to leaving for the field, BIS should have a map to the locations, if needed. There are multiple internet mapping programs available for use. It is best practice to organize your field visits to maximize efficiency and minimize time. This will enable BIS to be organized

and use time wisely. Do not depend exclusively on GPS or sequential directions to locate addresses.

J. Marginal or Internet-Only Locating Information

Marginal contacts are defined as any contact that does not have at least one piece of locating information (address, phone number, hangout, work address, school, etc.) Internet-Only contacts are define as any contact whose ONLY locating information is internet-based (website or app user name, e-mail, etc.)

Prior to initiating a marginal or internet-only contact to another BIS, the STI/HIV Research Analyst, Disease Intervention Program Manager, or STI/HIV Section Chief must be contacted to conduct a Lexis Nexis search to provide any additional information. Information on current interpreter service information can be found on the BIS Portal at http://www.kdheks.gov/sti_hiv

K. Interpreter Services

Most county health departments, clinics, and hospitals have interpreters either onsite or a service available for the BIS to use to communicate with patients. These resources should be utilized when available. When interpreter services are not available the BIS may use the state interpreter service provider.

L. STI Dispositions

- **A = Preventative Treatment**
  The partner/cluster was preventatively treated. Lab tests for the disease were negative or not done.
- **B = Refused Preventative Treatment**
  The lab tests for the disease were negative or not done.
  The partner/cluster was contacted and refused preventative treatment.
- **C = Infected, Brought to Treatment**
  The partner/cluster/reactor was positive for the disease.
  Adequate treatment occurred after the FR was initiated. The only exception to this is for syphilis FR's. A syphilis FR can only have a disposition of C once, all proceeding FRs must be E.
- **D = Infected, Not Treated**
  The lab tests for the disease are positive.
  The partner/cluster/reactor was contacted and refused treatment.
- **E = Previously Treated for This Infection**
  The partner/cluster/reactor was positive for the disease.
  Adequate treatment occurred before the FR was initiated.
- **F = Not Infected**
  The lab tests for the disease are negative. No preventative treatment is required.
- **G = Insufficient Information to Begin Investigation**
  There is not sufficient information to begin the investigation. This dispo should only be used to close an FR received from another state.
- **H = Unable to Locate**

The partner/cluster/reactor was not found after a thorough investigation.

- **J = Located, Refused Examination**
  The partner/cluster was contacted and refused testing for the disease suspected. This closure cannot be used with positive lab tests; this is a D.

- **K = Out of Jurisdiction**
  The partner/cluster/reactor was originally thought to be in your jurisdiction, but then you subsequently received information that the individual is not in your jurisdiction. There is sufficient information to begin an investigation in another jurisdiction.
- **L = Other**
  This disposition is to be used when no other disposition is appropriate. Consult your supervisor prior to using.

Internet-Only Disposition Codes

INT-C: The partner/cluster/reactor was informed generally of an urgent matter by the BIS & was tested and/or treated as a result of this internet contact.
INT-G: Not enough information to begin investigation/Profile not found.
INT-H: The partner/cluster/reactor was informed generally of an urgent matter by the BIS, but they did not respond.
INT-J: The partner/cluster/reactor was informed generally of an urgent matter by the BIS and client responded but refused testing/treatment.
INT-U: The profile of the partner/cluster/reactor was found, but due to security settings or other reason BIS was unable to send message.

M. Contact Types

Partners- A person who engages in any type of sexual or needle-sharing activity with the index patient.

P1- Sex partner
P2- Needle sharing partner
P3- Both sex and needle sharing partner.

Suspects- Individuals identified as the result of an interview with an infected person but who are not partners of that person

S1- People with symptoms of disease
S2- An unnamed partner of an infected patient
S3- Others who might benefit from a STI examination

Associates- Individuals initiated from cluster interviews who are named by persons that are not infected with disease.

A1- People with symptoms suggestive of disease
A2- Partners of other persons known to be infected
A3- Others who might benefit from a STI examination

N. CMR Dates:

- The Field Record initiation date is the date that the current investigator accepts the CMR. When the CMR is sent from one investigator to another, the investigator who is accepting the CMR must change the initiation date to reflect the change.
- Field record disposition dates are used to identify when that CMR is closed. For cases of syphilis and gonorrhea, the disposition date is the day of treatment or the day the CMR is accepted (which ever comes last). For HIV, the disposition date is the date that the investigator identified the patient as being positive (usually the same day that the case is accepted).
- The "Date Assigned for Interview" is generally the date that a BIS identifies the need for an interview with the patient. This is usually the day that the BIS receives the CMR. Some reasons for why the date may differ from the initiated date include if a diagnosis has not be confirmed (pending test results), the residence of the patient has not been established (patient may live out of the BIS jurisdiction or out of state), the BIS needs to speak with the provider prior to contacting the patient, or other legitimate reasons that may delay the investigation.
- The "Interview Date" is generally the date that the DIS interviews the client. However, if the client was interviewed prior to the DIS being aware of disease confirmation, the Interview Date should be modified to reflect the "Date Assigned for Interview"

O. Non-STI or "Other" Investigations

Other programs at KDHE (TB, Epidemiological Services, Immunization, etc.) will occasionally ask the STI/HIV Section for assistance with difficult investigations. All BIS (including contractual BIS) are expected to participate in any requests from KDHE once the request has been cleared with the Section Chief of the STI/HIV Section.

10. INVESTIGATIONS-GONORRHEA

A. Interview Periods

Gonorrhea- sixty (60) days prior to the onset of symptoms (if any) through treatment

B. Incorrect or insufficient treatment by a provider

Contact should first be made with the provider to ascertain the rationale for the treatment. The BIS should then provide education on current CDC recommendations for treatment. If a provider declines to treat the patient with medications generally accepted to be curative for the disease(s) for which the patient is being treated, the BIS should consult supervisor to determine how to proceed.

C. Wyandotte and Johnson County (Areas A & E) gonorrhea and chlamydia cases

In an effort to decrease the number of CMRs being routed back and forth between the two counties, **Wyandotte and Johnson Counties** will interview all gonorrhea cases that are diagnosed by providers in their respective counties without regard to where the patient resides.

11. INVESTIGATIONS-SYPHILIS

A. Contact with Patients: Before contact is made with the patient, the provider should be contacted to verify test results, the reason for examination, if symptoms are present at exam, if any partners were evaluated with the patient, treatment, etc. The provider should be notified that the patient will be contacted for interview (if appropriate).

B. **Syphilis Reactor Grid:** The following grid will be utilized to determine which laboratory reports require field investigation.

Reactive Non-Treponemal Tests:

	RPR ≤ 1:4	RPR ≥ 1:8
Over 65 Years of Age	**Close Administratively**	**Initiate for immediate investigation**
Prenatal	**Initiate for immediate investigation**	**Initiate for immediate investigation**
Confirmatory Test Pending	**Initiate for immediate investigation**	**Initiate for immediate investigation**
History of Prior Treatment	**Any titers 2 or more dilutions higher than the titer on the date of treatment will have an FR initiated for investigation. All others will be added to test history in TriSano and administratively closed.**	
When Reactors are Received Indicating Symptoms and/or Contact	**Initiate for immediate investigation**	**Initiate for immediate investigation**

Discordant Test Results: Patients who have a reactive non-treponemal test and a non-reactive treponemal test must be referred for retest after 1 month. Because the non-treponemal test is more sensitive than the treponemal test, it may be an indication of a very recent syphilis infection. The BIS must contact the provider/patient and recommend the additional testing and document appropriately.

Reactive Treponemal Tests:
Investigations **will** be initiated for all reactive treponemal tests (Igg, EIA, TPPA, FTA-ABS, and MHA-TP) that do **not** have an RPR result reported for the same day.

C. **Reactive Treponemal and Non-Reactive Non-Treponemal Tests:** In cases where a patient presents with a non-reactive non-treponemal test and a reactive treponemal test, the case will not be initiated for investigation. If BIS is asked to consult on a case with these test results, the patient (and/or their provider) should be advised that the CDC recommends treatment with a total of 7.2 mu Bicillin given as 2.4mu each one week apart. The patient (and/or their provider) should be advised that consultation with an Infectious Disease doctor may be indicated.

D. **Minimally Reactive Treponemal Tests:** Two consecutive minimally reactive treponemal tests in the absence of symptoms of infection or exposure to syphilis should be considered non-reactive.

E. Provider Reports

BIS may receive reactors via provider reports.

- Initially, BIS must perform a record search in TriSano.
- If the report received is on a patient with a previous history of syphilis, the titers should be evaluated to determine if the report constitutes a new case or not.
- If it is determined **not** to be a new case, the new lab should be entered into the existing CMR.
- If the report **does** constitute a new case, or if the patient does not have a prior history in TriSano, a new CMR should be entered into TriSano and initiated for investigation.

F. **Pregnant women with a history of treatment:** Pregnant women should be retested to ensure that the titer remains stable or lower than the titer at the time of treatment (to rule out re-infection or newly acquired infection).

G. **Unable to verify previous treatment:** If a patient indicates they have been previously treated for syphilis, but you are unable to obtain documentation verifying the treatment (e.g. treatment in another country, treatment so long ago that records are not available, etc), the following steps should be taken:

- Obtain a second specimen to ensure the titer is stable. If the titer is NOT stable (i.e. four-fold or greater increase), case will be treated as an early case.
- Determine if the case is new (acquired within one year) or older than 12 months or unable to determine through epidemiology and partner services.
- If the case is over 12 months or unable to determine the duration immediately advise the provider that the patient should be treated with a total of 7.2mu Benzathine Penicillin G L.A., administered as 3 doses of 2.4 million units IM each at one-week intervals (in accordance with CDC recommendations) and document this in the encounter in the CMR.
- If the provider treats the patient the disposition is “C” diagnosis 740.
- If provider refuses to treat patient, it should be documented that the provider was advised and refused. The disposition should be “L” diagnosis 740.

H. Obtaining syphilis or HIV test results from KHEL:

To request a laboratory result from KHEL, send an e-mail to the Disease Intervention Program Manager, Prevention Program Manager, or STI/HIV Section Chief. The e-mail must include the individual lab number and the information requested. No personal identifying information should be included. The BIS may not call KHEL directly.

I. **Diagnosis Determination:** Symptoms documented at the time of initial examination or observed during the original interview are used to determine diagnosis. If symptomology is questionable, discuss case with supervisor.

- Are symptoms present at interview (or at initial exam)?
- Yes: diagnosis made based off of symptomology unless contradicting information is identified. (i.e. chancre=710)

- No: diagnosis will be documented as 730 until/unless sufficient evidence (as determined by program management) is identified to change diagnosis to 740 or 745. Diagnoses of 740 or 745 must be approved by Section Chief or Program Manager.

J. Interview Period

Primary (710) – 90 days prior to appearance of symptoms through treatment date plus the time from treatment to interview.
Secondary (720) – 6 ½ months prior to appearance of symptoms through treatment date plus the time from treatment to interview.
Early Latent (730) – 1 year prior to treatment date plus the time from treatment to interview.

K. Treatment of Syphilis Contacts:

- All sex partners that have had sexual contact with an early syphilis case within the 90 days preceding treatment must be preventatively treated at the time of testing.
- Sex partners whose last sexual exposure to an early case of syphilis was **more** than 90 days from the date of treatment should be tested for syphilis and treated based on test results.

L. Before a syphilis investigation can be closed:

- All interviews and CMRs associated with the interviews (contacts, suspects, associates) must be entered into TriSano & closed.
- There must be (at a minimum) one re-interview completed on the OP
- There must be cluster interviews completed on all partners
- There must be documentation of a current HIV test (or refusal by patient to be tested)
- Visual Case Analysis for all early syphilis cases must be scanned and uploaded into TriSano as an attachment.
- Contacts with a B, H, or J dispositions and cases with a D disposition must be worked by a minimum of two (2) BIS.

12. INVESTIGATIONS-HIV

A. Interview Period

If a known risk period can be determined, it should be used to establish an interview period (e.g., patient used injection drugs five (5) years ago for the first time, interview period would go back five (5) years). If no known risk period can be established, the interview period should be ten years from the date of onset of symptoms. If no symptoms are present than the interview period should be ten (10) years. If the patient has had a previous documented negative test, the interview period can be shortened back to six (6) months prior to the documented negative test.

B. Previous Positives-Original Patient (discovered during interviews): If, during the course of an interview, a patient discloses that they have previously tested positive for HIV, the following steps should be taken:

- Continue to perform a FULL interview on the patient, including when/where they previously tested positive.
- Verify with the client that they are actively engaged in medical care (defined as within the last eight (8) months). Document the facility/provider they receive medical care from.
- Call the STI/HIV Surveillance eHARS Data Manager (785-296-5597) to do a record search.
- If STI/HIV Surveillance Program is able to verify the previous positive status, the FR will be dispo'd as "1" and the interview does NOT need to be written up. Verify with the eHARS Data Manager that labs have been received on the patient within the last eight (8) months.
- If the client discloses that they are not actively engaged in care, or no record of care can be found for the client, the client should be referred to the appropriate Linkage to Care Coordinator (LTCC).
- If STI/HIV Surveillance is unable to verify a previous positive, then the patient will need to be dispo'd appropriately ("2" or "5"); the interview will be completed in TriSano.

C. Previous Positives-Contacts: Any contacts being sought for the purposes of disease investigation that turn out to be previously positive for HIV need to be notified of their current exposure, tested for syphilis, and cluster interviewed.

D. Reports Given Directly to BIS

Upon receiving a positive HIV report:

- Take pertinent information about the client. (Name, address, date of birth, treatment/care status, etc.)
- Call STI/HIV Surveillance eHARS Data Manager at 785-296-5597 to see if patient is already reported as positive.
- If patient is not already reported as a positive HIV the BIS will create a CMR.
- If the STI/HIV Surveillance eHARS Data Manager confirms that the patient is a previous HIV positive case, Central office will create the CMR. The patient's previous history should not be shared with the original reporter or care provider. If the BIS is questioned about the outcome of the referral, the BIS should respond that it has been taken care of without giving any specific information.

E. Management of individuals that test positive for HIV at Red Cross

Red Cross will not contact these individuals unless requested by KDHE.

BIS must discuss the following items with the individual for the Red Cross:

- Ask the donor if they have donated blood in the last 5 years. If yes, obtain the name and location of the collecting entity.
- Inform the donor that he/she is permanently deferred from donating to the American Red Cross and that their information will be added to the Donor Deferral Registry. The Donor Deferral Registry is not released to anyone.
- Ask the donor if he/she would like to receive the "donor packet" that the Red Cross sends to deferred donors.
- The information gathered must be documented in TriSano with a "Task" sent to the Section Chief or Program Manager to forward to the STI/HIV Prevention Program Manager.

F. Investigations may not be closed until

- All interviews and all CMRs are entered in TriSano.
- Cluster interviews have been completed on all partners.
- There must be documentation that the patient was either tested for syphilis or refused testing.
- Contacts with a 4, 7, H, or J dispositions and cases that are not interviewed must be worked by a minimum of two (2) BIS.

G. Spousal Notification Requirements

On May 20, 1996, President Clinton signed legislation requiring that a "good faith" effort be made to notify any spouse of a known HIV-infected individual of potential exposure to the virus and that the spouse be encouraged to seek testing. A spouse is defined as "any individual who is the marriage partner of an HIV-infected patient, or has been the marriage partner of that patient at any time within the 10-year period prior to the diagnosis of HIV infection.

H. Children of HIV+ patients

When interviewing HIV positive patients, BIS must ask specifically if the patient has any children. If a patient does have children, BIS must provide intensive counseling explaining risks and methods of exposure for children (perinatal, breastfeeding, blood exposure, etc.). This counseling must be clearly documented on the Interview Record write up. If the patient is a biological father, it is necessary to explain that his child(ren) may be infected; therefore the mother(s) of his child(ren) within the interview period must be tested. If the patient is a biological mother, all children born during the interview period will be considered a Suspect (S3) and a CMR will be initiated with all pertinent information. Parents will be counseled that the child(ren) born during the interview period should be tested. The responsibility to get the child(ren) tested will belong to the parent. The BIS should, however, suggest to the parent that they contact the child's primary caregiver or their own provider to test the child. Local Health Departments may be suggested as an alternative, if the health department agrees to test the child. After documenting the counseling session on the CMR close the FR as an "L". If the BIS is aware that a test was done and is able to get the results, the CMR may remain open until test results can be obtained. If no high-risk interview period can be determined, all children born within the preceding ten (10) years should be initiated as suspects.

I. HIV DISPOSITIONS

- **1 = Previous Positive-**The partner/cluster is aware of his previous positive status from previous HIV testing. The reactor has had additional positive HIV tests prior to this test.
- **2 = Previous Negative, New Positive-**The partner/cluster/reactor has had previous negative HIV testing, but now tests positive. This closure requires the completion of an interview record.
- **3 = Previous Negative, Still Negative-**The partner/cluster has had previous negative HIV testing, and now tests negative.
- **4 = Previous Negative, Not Re-tested-**The partner/cluster has had previous negative HIV testing. The partner/cluster is counseled, but not re-tested now.
- **5 = Not Previously Tested, New Positive-**The partner/cluster/reactor has had no previous HIV test, and now tests positive. This dispo should also be used when a reactor refuses post-test counseling and previous testing history is unknown. This closure requires the completion of an interview record.
- **6 = Not Previously Tested, New Negative-**The partner/cluster has had no previous HIV test, and has tested negative now.
- **7 = Not Previously Tested, Not Tested Now-**The partner/cluster has had no previous HIV test, and is not tested now.
- **G = Insufficient Information to Begin Investigation-**There is not sufficient information to begin the investigation. This dispo should only be used to close an FR received from another state.
- **H = Unable To Locate-**The partner/cluster/reactor was not found after a thorough investigation.
- **J = Located, Refused Counseling and Testing-**The partner/cluster was contacted and refused counseling and/or testing for the disease suspected.
- **K = Out Of Jurisdiction-**The partner/cluster/reactor was originally thought to be in your jurisdiction, but then you subsequently received information that the individual is not in your jurisdiction. There is sufficient information to begin an investigation in another jurisdiction.
- **L = Other-**This disposition is to be used when no other disposition is appropriate. Consult your supervisor prior to using.

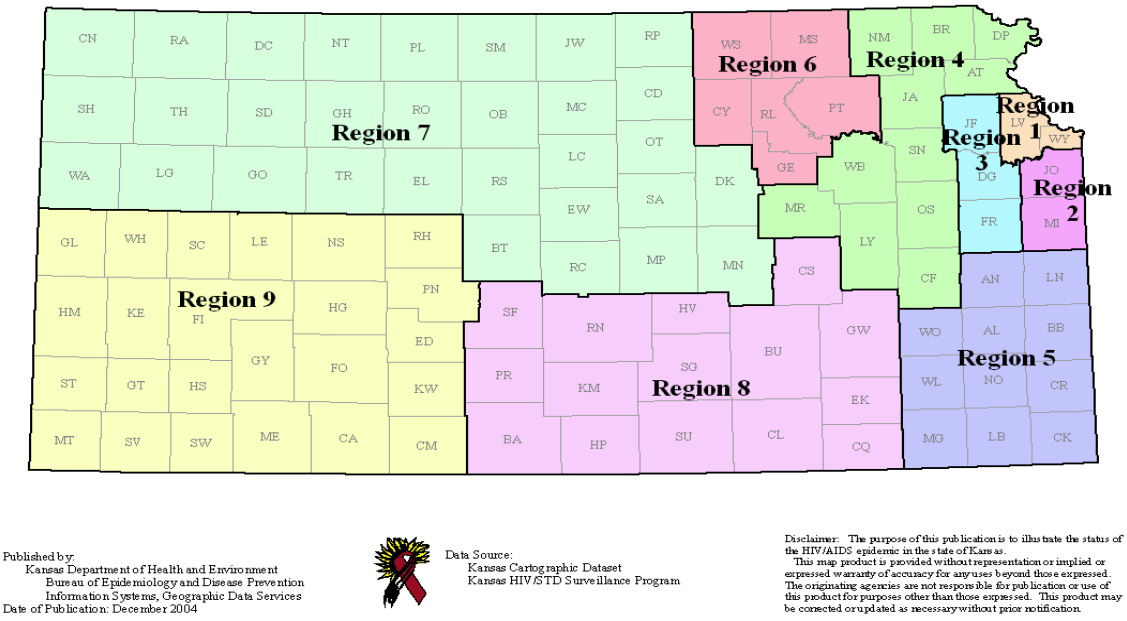
Internet-Only Disposition Codes:

- **INT-C:** The partner/cluster/reactor was informed generally of an urgent matter by the BIS & was tested and/or treated as a result of this internet contact.
- **INT-G:** Not enough information to begin investigation/Profile not found.
- **INT-H:** The partner/cluster/reactor was informed generally of an urgent matter by the BIS, but they did not respond.
- **INT-J:** The partner/cluster/reactor was informed generally of an urgent matter by the BIS and client responded but refused testing/treatment.
- **INT-U:** The profile of the partner/cluster/reactor was found, but due to security settings or other reason BIS was unable to send message.

13. LINKAGE TO CARE (LTC) REFERRALS

All new HIV infections **must** be **immediately** referred to the appropriate Linkage to Care Coordinator (LTCC). The LTCC are required to respond to BIS within one (1) hour of contact during regular business hours (M-F 8A-4P). Please refer to the following map to find LTCC contact information, and to determine LTC coverage for your area.

HIV/AIDS Community Planning Regions



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Kansas HIV/STD Surveillance Program

Disclaimer: The purpose of this publication is to illustrate the status of the HIV/AIDS epidemic in the state of Kansas.
This map product is provided without representation or implied or expressed warranty of accuracy for any uses beyond those expressed. The originating agencies are not responsible for publication or use of this product for purposes other than those expressed. This product may be corrected or updated as necessary without prior notification.

Linkage to Care Coordinator (LTCC) Coverage

Kenny Cochrane Regions 3, 4, 5, 6, and 7
785-213-6851
kcochrane@kdheks.gov

Melanie Wright Regions 8 and 9
316-213-2309
mawright@kdheks.gov

Kansas City Free Health Clinic Regions 1 and 2
3515 Broadway
Kansas City, Mo 64111
816-990-2411

(Note: Patient's residing in Johnson, Leavenworth, Miami or Wyandotte counties will be referred to a Title I Linkage to Care Coordinator in accordance with jurisdictional boundaries.)
Linkage to Care Referral Process:

1. BIS will contact the appropriate LTCC prior to any attempt to contact the patient or the provider in order to determine a joint course of action.

    a. If the patient is aware of their HIV diagnosis the LTCC will initiate contact with the patient and attempt to schedule a joint meeting with the LTCC, BIS, and the patient.
    b. If the patient is not aware of their HIV diagnosis the BIS will contact the patient and attempt to schedule a joint meeting with the LTCC, BIS, and the patient.
    c. If it is unknown to either the BIS or the LTCC if the patient is aware of their diagnosis, the BIS and LTCC will work together to determine the most appropriate course of action.

2. In the event that LTCC cannot be contacted to meet with a client (field visit after normal working hours, patient shows up unexpectedly at clinic, etc.), BIS will attempt to contact the LTCC to allow the LTCC to speak with the client to set up a meeting time for LTC. If the LTCC cannot be reached, the BIS will provide the patient with a business card for the appropriate LTCC, and explain to the client that LTC is the next standard step after an HIV positive test result, and that the LTCC will be calling them as soon as possible (the next business day if after hours), and document at what phone number the client prefers to be contacted. BIS will explain to the patient that the LTCC will assist with linkage to medical care, assist with medical eligibility, social services, and support. (This **does** include clients that are already under a doctor's care.) The LTC program should be presented as the next standard step, but the client DOES have the right to decline the referral.

3. In the event that the patient declines to receive LTC services, BIS will provide a business card for the appropriate LTCC. The LTCC will then be notified by the BIS that the patient declined LTC services. BIS will provide all pertinent patient information to the LTCC so that follow-up can be initiated.

4. Documentation of how the referral was made will be documented on the Interview Record in TriSano.

Linkage to Care Process in Leavenworth, Miami, Wyandotte and Johnson Counties:

During Regular KC Care LTC Hours:

1. When interviewing a new HIV patient, the BIS discusses and promotes KC Care LTC.
2. If the patient is interested, the BIS will call the pager number for the KC Care LTC program.
3. The BIS must wait 20 minutes for the KC Free LTC program to respond by phone during normal business hours. If KC Free LTC program does not respond within 20 minutes, see "If KC Care LTC is unavailable" below.
4. When the KC Free LTC program responds, they will provide information to the client about their services, collect basic demographic & testing information, and set up an appointment to meet with the client.

If KC Care LTC is unavailable:

1. Obtain consent from the client to provide KC Care with their information.
2. Verify name, date of birth, best number to reach the client, address for the client. Notify patient to expect a call within the next 24 hours from KC Care.
3. When The KC Care LTC program responds, provide collected information to LTC worker who will then contact the patient.
5. Follow up at re-interview or by phone to make sure that the referral was successful.

*****If client declines LTC services through KC Care, the appropriate LTCC for KDHE should be notified and given patient's information for follow-up.**

14. COMPREHENSIVE RISK COUNSELING AND SERVICES

A referral to Comprehensive Risk Counseling and Services (CRCS) is indicated when BIS encounter individuals that are HIV-positive with high risk behaviors, difficulty with treatment compliance, or HIV-negative individuals that have behaviors that put them at high risk of becoming HIV infected.

The BIS needs to ask the patient to complete the Substance Use and Mental Illness Symptoms Screener (SAMISS). Also, the BIS need to complete the Comprehensive Risk Counseling Services Referral Form (CRCSRF). This can be done using information gathered during the interview. Both forms are available on the BIS Portal and must be given to the CRCS representative to complete the referral.

CRCS also takes referrals for the Intensive Prevention Intervention (IPI) program which is designed to educate an individual on the importance of informing sex and needle sharing partners of their HIV-positive status. IPI is also designed to inform individuals and make them aware of existing state law (K.S.A. 21-3435): Exposing another to a life threatening communicable disease. This intervention will further be oriented toward assisting a client by actively referring them to the STI/HIV Care Program, substance abuse, or other appropriate programs including educational and support programs offered through community and social services agencies.

Goal: Promote the adoption and maintenance of HIV risk reduction behaviors by clients with multiple complex problems and risk reduction needs.

Contact Melba Sutton
Bureau of Disease Control
Office: 785-296-8793
Mobile: 785-213-7403

15. INTERNET PARTNER SERVICES (IPS)

A. BACKGROUND

The Internet is a powerful medium for communication and, as such, is a valuable tool for facilitating STI/HIV Partner Services (PS). Research has shown the Internet to be a venue for facilitating STI transmission as well as for disease control and health promotion. Because Access to the Internet has become nearly universal for most Americans, STI Control Programs have been encouraged to incorporate the Internet into their prevention efforts. With the rise of Internet-based social networking, dating, and sex sites, anecdotal evidence suggests that increasing numbers of men who have sex with men (MSM) as well as other high-risk populations are meeting online to arrange anonymous sexual encounters. As a result, individuals who are newly diagnosed with STIs/HIV may know only the screen names and/or e-mail addresses of their sex partners.

Because Internet Partner Services will typically take place within an online adult community or through an adult oriented website which are overtly sexual in nature, employees conducting Internet Partner Services must be culturally competent, well prepared to view explicit content, thoroughly trained on how to best use the internet for partner services, and properly supervised.

It is important to remember that the websites where patients meet sex partners and from which IPS is being conducted do not have a public health mission. Most of them are private businesses whose primary mission is to generate revenue. It is possible that IPS may be perceived as a threat to that mission. When conducting IPS through a website, it is important to be aware that you are a member of the community and are subject to the rules and regulations of the website. It is imperative to be aware of such rules and regulations pertaining to IPS prior to joining the site. Rules and regulations regarding Internet interventions will vary from site to site. Some websites will allow one type of Internet effort and not another, for example, they will allow passive outreach, but not IPS. Other websites may require separate profiles for IPS and outreach and will state that they should not be used interchangeably. Being aware of the rules and regulations for each website and following those policies will help ensure that Internet efforts that are conducted within private businesses are preserved.

BIS need to be aware that different websites have different options that may help maintain or potentially breach confidentiality. For example, on www.bgclive.com (Black Gay Chat), after creating a profile, it is necessary to choose "My Account Options" and then choose "Turn Who I Recently Visited Off." If this is not done, when an Internet partner's profile is viewed, it will document the health department's visit on that individual's profile.

The fast paced and anonymous nature of the internet can also foster methods for communicating in ways that would generally not be acceptable in 'real world' social interactions. The social norms that govern how we communicate in public are significantly altered in online communities, especially networks that are centered on meeting for sex. Communication in social networks designed around finding sex partners is often brief and to the point while being devoid of many of the social norms that exists in face to face communication. E-mails between members of these communities are often incomplete sentences containing few words and may even be perceived as rude or abusive by an 'outsider'. When communicating electronically it is important to remember that this form of communication is void of the normal voice inflections or facial expressions and that these communities may have unique methods and ways of communicating. As a person conducting Internet Partner

Services, the messages you send will most likely be outside of the community norms, structured in a more formal way, and void of any verbal clues to authenticate the message. It is important to remember that because of these unique issues found within online communities, the e-mails you send to contacts may at first be perceived as spam or a hoax.

The first step in understanding an online community is to review the marketing materials, the Frequently Asked Questions (FAQ), the images used, and the details of the exterior, such as the URL, the slogan, and website design. A website's 'personality' may be reflected in the URL or in the name of the community. Websites with names like Manhunt, DaddyHunt, VeggieDate, SinglesWithScruples, and AdultFriendFinder reveal a great deal about their mission and the norms of the community they support.

B. IPS Protocol

1. All policies/procedures/protocols that apply to traditional partner services also apply to IPS.

2. All staff performing Internet Partner Services must abide by the policies and procedures for Information Technology (IT) as specified by the Kansas Department of Health and Environment (KDHE) as well as the Local Health Department(s) where they are stationed.

3. When creating a profile to perform IPS on any online venue, the official BDCP logo should be used as the account picture, unless prohibited by the venue.

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4. Personal social media, e-mail accounts, or profiles should never be used for IPS.

5. During all interviews (original, re-interview, and cluster interviews), BIS MUST ask clients
   - how often the client uses the internet to meet partners
   - where the client goes on the internet to meet sex partners
   - what apps the client uses to meet sex partners
   - sex partner's usernames for websites/apps identified
   - e-mail addresses for all sex partners

6. Internet Partner Services will be used only when conventional locating information is not available (i.e. no phone number, address, or other locating information is available) or when conventional means to find partners/clusters have been unproductive (i.e. phone number, address, or other locating information is incorrect or does not produce a response from the patient).

7. All internet information collected during interviews must be documented in TriSano, along with any attempts to contact clients.

8. Prior to initiating IPS, BIS should attempt to obtain the geographic location of the individual they are trying to contact. This is often listed in the individual's online profile. Knowing the geographic location of the sex partner allows the BIS to provide appropriate referral information (i.e., clinic locations, clinic times).

9. When it becomes necessary to contact a patient or sexual partner/cluster by website, app, or other electronic means, BIS must use the following message exclusively:

   Dear _____,
   There is an urgent health matter which requires your immediate attention. Please call (insert BIS name) at (insert phone number) as soon as possible.
   Thank you.

C. Facebook Protocols

Each BIS will create a Facebook account using their work e-mail for purposes of contacting clients confidentially as needed for public health investigations.

1. This account is to be used exclusively for IPS.
2. All accounts must be approved by Disease Intervention Program Management.
3. This must be a separate account from any personal use or account.
4. No friends should be added, and no pages, groups, etc. should be followed on your work Facebook Account.
5. Each user must use their own name as per FB usage policy.
6. Each user's profile picture should be the KDHE-BDCP logo. This logo can be found on the BIS Portal

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Department of Health and Environment
Disease Control and Prevention

7. Username and password must be kept on file with supervisor.
8. BIS must document all contact with clients through FB, as with all forms of contact with clients.
9. When sending a message to a patient through Facebook, BIS must use the following message exclusively:

   Dear _____,
   There is an urgent health matter which requires your immediate attention. Please call ___(insert BIS name)_____ at ___(insert phone number)___ as soon as possible.
   Thank you.

10. If patients respond and want additional information, the following message can be used:

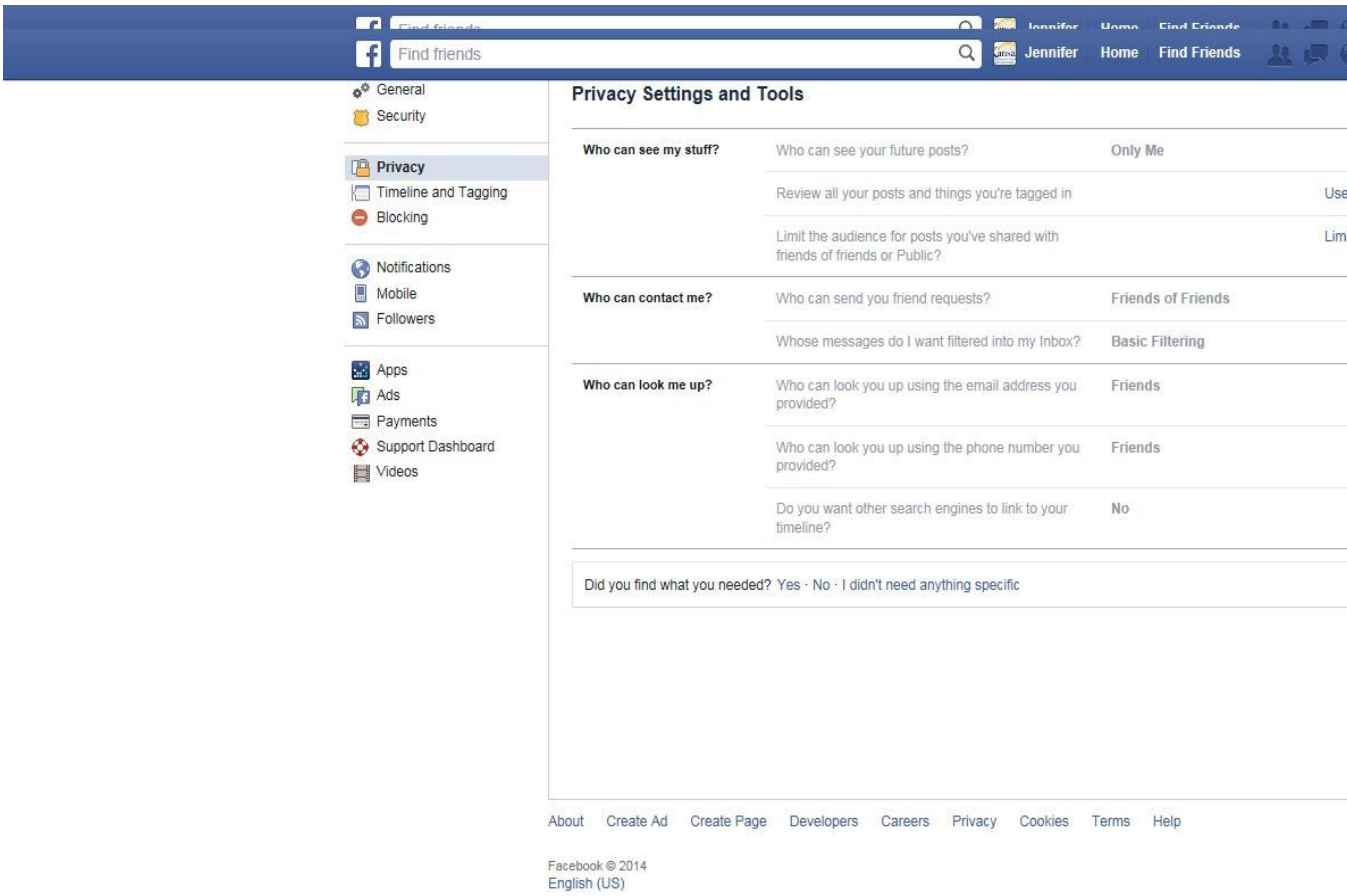
    Due to confidentiality, I am unable to give any specific medical information online, but this is an URGENT health matter. Please contact _____ at _____ as soon as possible.

11. No confidential information can be shared through Facebook, nor any other type of social media or apps.
12. The BIS who sends the message to the patient is responsible for filling in the "Internet Partner Services" Dispo Code on the CMR. The Dispo Codes for IPS in Kansas are as follows:

    - **INT-C:** The partner/cluster/reactor was informed generally of an urgent matter by the BIS & was tested and/or treated as a result of this internet contact.
    - **INT-G:** Not enough information to begin investigation/Profile not found.

- **INT-H:** The partner/cluster/reactor was informed generally of an urgent matter by the BIS, but they did not respond.
- **INT-J:** The partner/cluster/reactor was informed generally of an urgent matter by the BIS and client responded but refused testing/treatment.
- **INT-U:** The profile of the partner/cluster/reactor was found, but due to security settings or other reason BIS was unable to send message.

13. Privacy Settings for BIS FB account should be set up as follows:



Note: When BIS send messages to patients, sometimes security settings will only allow a BIS to send contacts to the "other" folder. BIS will need to talk to their area supervisor regarding payment for any messages sent to the patient's inbox (most people who you are not connected to on Facebook can be messaged for a fee of $1 per message). Keep in mind when sending messages that this fee is assessed per message and not just for the initial message (however as everything with social media, this is subject to change).

16. BIS PORTAL INFORMATION

Many of the pertinent documents, forms, and policies for BIS can be found on the KDHE BIS Portal. To access the portal, follow the below instructions:

A. Access the STI/HIV Section Website at: http://www.kdheks.gov/sti_hiv/

B. Click on the "Public Health" icon on the bottom left of the screen:

C. Enter the password "Intervention" when prompted

D. Call Central Office at 785-296-5596 if you encounter any problems accessing the portal.

17. ACRONYMS & ABBREVIATIONS:

~-About
@-At
Ø-None, No, or Not
Ⓡ - Right
Ⓛ -Left
APPT-Appointment
BDCP-Bureau of Disease Control and Prevention
BID-Twice a Day
BIS-Behavioral Intervention Specialist (used interchangeably with DIS)
BV-Bacterial Vaginosis
CDC-Centers for Disease Control and Prevention
CLIA (test)-Chemiluminescence Immunoassay (Confirmatory test for syphilis)
CLT-Client
CT-Chlamydia (trachomatis)
D/C-Disconnected
DIS-Disease Intervention Specialist (used interchangeably with BIS)
DNS-Did Not Show
DOB-Date of Birth
DR-Doctor
DTF-Down to Fuck
DX-Diagnosis
EIA-Enzyme Immunoassays (Screening test utilized for multiple diseases)
F/U-Follow-Up
FR-Field Record
FTA-ABS-Fluorescent Treponemal Antibody Absorption (Confirmatory test for syphilis)
FV-Field Visit
GC-Gonorrhea
HBV-Hepatitis B Virus
HCV-Hepatitis C Virus
HD-Health Department
HPV-Human Papillomavirus (Genital Warts)
HSV-Herpes Simplex Virus
HX-History
IFA-Immunofluorescence Assay (Confirmation test for HIV)
IX-Interview
KACHA-Kansas Advisory Council on HIV and AIDS
KDHE-Kansas Department of Health & Environment
IDU-Injection Drug User
IPS-Internet Partner Services
IR-Interview Record
IVDU-Intravenous Drug User
IX-Interview
LHD-Local Health Department
LM-Left Message
LMOMTRC-Left Message on Machine to Return Call
LMTRC-Left Message to Return Call
LN or L/N-Lexis Nexis
LR-Left Referral
LSE-Last Sexual Encounter/Exposure
LTC-Linkage to Care
LTCC-Linkage to Care Coordinator
LVM-Left Voice Mail
LX-Lesion
MD-Doctor
MR-Medical Record
MSG-Message
MSM-Men Who Have Sex with Men
NAAT-Nucleic Acid Amplification Test
OOJ-Out of Jurisdiction
OP-Original Patient
OTC-Over the Counter
PC-Phone Call
PCP-Primary Care Physician / Provider
PCR-Polymerase Chain Reaction (HIV test used to amplify a single or few copies of a piece of DNA)
PG-Pregnant
PMD-Primary Medical Doctor
PT-Patient
PO-By Mouth
PP or P/P-Palmer Plantar
PV-Provider Visit
QID-Four Times a Day
RC-Returned Call
RCV'D-Received

REC'D-Recommended
RPR-Rapid Plasma Reagin (Screening Test for Syphilis)
RS-Record Search
RVS-Reverse Search
RX-Prescription
SP-Sex Partner
STS-Serological Test for Syphilis
TID-Three Times a Day
TPPA-Treponema Pallidum Particle Agglutination Assay (Confirmatory test for syphilis)
TX-Treatment
VCA-Visual Case Analysis
VM-Voice Mail
W/-With
W/E-Weekend
W/0-Without
Wks-Weeks

Kansas Department of Health and Environment

Bureau of Disease Control and Prevention (BDCP)

Data Security and Confidentiality Policy

For HIV, Viral Hepatitis, Sexually Transmitted Infection, Tuberculosis and Vaccine-Preventable Disease (Immunization) Programs

Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action

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ACRONYMS

AES – Advanced Encryption Standard

BDCP – Bureau of Disease Control and Prevention

CDC – Centers for Disease Control and Prevention

DSA – Data Sharing Agreement

FTP – File Transport Protocol

HIV – Human Immunodeficiency Virus

HRSA-Health Resources and Services Administration

IRB – Internal Review Board

KDHE – Kansas Department of Health and Environment

MOA – Memorandum of Agreement

PII – Personally Identifiable Information

OITS – Office of Information Technology Services

ORP – Overall Responsible Party

SAC – Security Advisory Committee

SDN – Secure Data Network

SGF-State General Funds

STI – Sexually Transmitted Infections

TB – Tuberculosis

VPD – Vaccine Preventable Disease

VPN – Virtual Private Network

1.0 PROGRAM POLICIES AND RESPONSIBITIES

The Bureau of Disease Control and Prevention's (BDCP) Security and Confidentiality Policy was developed to comply with the Centers for Disease Control and Prevention (CDC) "Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, And Tuberculosis Programs: Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action". This policy addresses programs within the BDCP.

The BDCP Security and Confidentiality Policy will be reviewed and updated as needed and / or annually. Staff will be informed of the changes and the network location of the most recent policy.

OVERALL RESPONSIBLE PARTY

The overall responsible party (ORP) for the security of public health data in BDCP shall be the BDCP Bureau Director. The ORP shall be responsible for any public health data that BDCP collects or maintains. The ORP shall further be responsible for establishing and maintaining a Security Advisory Council (SAC). The current SAC shall be chaired by the ORP and contain representatives from each of the sections within BDCP.

Members of the SAC include:

- Brenda Walker – BDCP Director
- Phil Griffin – Deputy BDCP Director and TB Section Chief
- Jennifer VandeVelde – STI/HIV Section Chief
- Tim Budge – Immunization Section Chief
- Kelsey Gordon – STI/HIV Surveillance Program Manager
- Brad Williams –Acting Manager, KDHE Computer Support

ACCESS AND ROLES

Persons with access to personally identifiable information (PII) should be kept to a minimum. The ORP and SAC will determine the role, system access, and level of access for BDCP staff and anyone with access to BDCP PII. The ORP and SAC will also consult with program staff in KDHE Office of Information Technology Services (OITS) to determine OITS staff with system access and level of access.

List of roles, system access, and level can be found in Appendix 1.

Within 24 hours of termination of employment, the Section Chief of the respective section to which the former employee belonged will ensure removal of the former employee's access to all systems that the employee had access to and will notify all members of the SAC that this has been completed.

SECURITY BREACH

All staff are responsible for reporting suspected security breaches to their Section Chiefs. Section Chiefs are responsible for reporting the suspected security breach to the ORP.

A breach of confidentiality will be immediately investigated to assess causes and implement remedies.

A breach of confidentiality is defined as: Disclosure of confidential information to: 1) any person outside BDCP who lacks legal right of access, or 2) to BDCP employees who do not need access to the information for completion of assigned duties.

BREACH OF CONFIDENTIALITY INVESTIGATION PROCESS

A breach of security involving confidentiality or PII data must be immediately reported to the **ORP.** Documentation of the breach will be maintained by the **ORP** describing the investigation findings and corrective actions taken.

A breach that results in the release of private information about one or more individuals (breach of confidentiality) should be reported immediately to the **ORP**. The breach will then be reported to the Director of the Division of Public Health. In consultation with appropriate legal counsel, the ORP will determine whether a breach warrants report to law enforcement agencies.

Any breach that results in the release of personally identifiable information to unauthorized persons must be reported to the appropriate entity from which provides funding to the impacted program (CDC, HRSA, SGF etc.)

SECURITY AND CONFIDENTIALITY TRAINING

NEW BDCP EMPLOYEES

- All newly hired staff members must receive and successfully pass Security and Confidentiality training through KS-TRAIN within one week of hire.

- All newly hired staff members must sign a confidentiality agreement which will be kept on file by ORP within one week of hire.
- All KDHE staff members must receive generic security awareness training upon hire at KDHE's New Employee Orientation. Documentation of this training shall be kept in each employee's personnel file within Personnel Services.

ALL BDCP EMPLOYEES

All BDCP staff must receive annual Security and Confidentially Training. Training will be based on this document and will cover:

- Personal responsibilities
- Procedures for ensuring physical security of PII
- Policies and procedures for data sharing
- Procedures for reporting and responding to security breaches
- Review of relevant laws and regulations

After annual training, all BDCP staff will re-sign a confidentiality agreement and verify that they attended the annual training. This document will be kept on file by the ORP.

STATE OF KANSAS STAFF (NON BDCP) WITH ACCESS TO BDCP PII

All State of Kansas (non-BDCP) staff who have access to BDCP PII shall receive annual security and confidentially training. Training will be based on this document and will cover:

- Personal responsibilities
- Procedures for ensuring physical security of PII
- Policies and procedures for data sharing
- Procedures for reporting and responding to security breaches
- Review of relevant laws and regulations

After annual training, staff will re-sign a confidentiality agreement and verify that they attended the annual training. This document will be kept on file by ORP.

STATE OF KANSAS STAFF (NON BDCP) WITH NO DIRECT ACCESS TO BDCP PII

All State of Kansas (non-BDCP) staff that do not have direct access to BDCP PII (but may have access to the physical location of BDCP) shall sign a confidentiality agreement and re-sign the agreement annually. These documents will be kept on file by the ORP.

EXTERNAL PARTNERS (PROGRAMS, BUREAUS, AGENCIES, ETC.)

External partners are defined as entities outside of BDCP with whom data must be shared in order to fulfill the public health duties of the bureau. This may include other programs or bureaus within KDHE, other state agencies and/or contractors of KDHE.

- All external partners will sign a confidentiality agreement which will be kept on file by the ORP.
- All external partners will receive program specific security and confidentiality training annually.

DISASTER RECOVERY PLAN

A data disaster recovery plan was developed and reviewed for KDHE by the OITS.

2.0 DATA COLLECTION AND USE

- Data collected by BDCP Programs are for the purpose of public health related to HIV/AIDS, STI, TB, and VPDs. Public health purposes include disease surveillance, disease and premature death prevention, or health promotion among members of a community through activities such as:
  - Assessing the health needs and health status of a community through public health surveillance and epidemiologic research
  - Developing public health policy
  - Responding to public health needs and emergencies
  - Evaluating public health programs
  - Treatment

- Before implementing data collection, BDCP programs shall specify minimum data elements and consider whether collection and use of personally identifiable data will be necessary to achieve their public health goal.

- The minimum information requirement will vary based on the activity. When considering a new data collection, consider the following guidelines:
  - Specify minimum data elements, and include only the information needed to achieve the public health goal(s) including required reporting data elements.
  - Minimize or avoid collecting information because it might be of use later or because it is easily accessible.
  - Refer to similar high-quality data-collection efforts or data-sharing activities with proven success.
  - Avoid unnecessary retention or creation of multiple data collections or data management systems (the more collections/systems, the greater the complexity of security management).

- The use of identifiable data must be approved by the SAC first, then obtain the Internal Review Board (IRB) approval, and the signing of a confidentiality agreement regarding rules of access and final disposition of the information. The use of non-identifiable data for research is generally permissible but might still require IRB approval, depending on the amount and type of data requested. Section Chiefs should consult applicable guidance on research versus practice and human subject regulations and with IRB Chair to determine if IRB approval is necessary.

3.0 DATA SHARING AND RELEASE

This standard applies to the sharing of data with other public health programs that might need access to data for a related public health function. The SAC must approve any BDCP data sharing or data release.

Prior to sharing PII, the ORP and appropriate section chiefs must assess:

- Is access to PII necessary to achieve a specified public health function?
- Have all alternatives to sharing such data been explored?
- Is the proposed use within the scope of your data-release policy and for a legitimate public health purpose?

DATA SHARING

DATA SHARING OUTSIDE BDCP

For individual cases, data may be shared without written agreements with local health departments, health care providers, and other KDHE programs if there is a public health need.

For all other situations where data sharing (datasets) is requested, written agreements must be established prior to data sharing. The written agreements will be developed and approved by SAC.

- Memorandum of Agreement (MOA) – internal; other disease programs within KDHE
- Data Sharing Agreement (DSA) – external; LHD, university, NGO, research, etc.

DATA SHARING WITHIN BDCP

Information about reportable conditions can be exchanged freely between all programs within BDCP authorized to conduct surveillance for those conditions as necessary for public health purposes.

DATA RELEASE

- Surveillance data will be published and posted on the BDCP website on an annual basis. This includes standard tables, graphs, and annual reports.
- Surveillance data will not be released with cell sizes less than or equal to 5. Exceptions to this release will be evaluated by the Program Manager and Section Chief on a case-by-case basis to ensure that data are not identifiable.

- In the calculation and release of rates, care must be taken where the numerator and/or denominator are small or if the difference between the numerator and denominator is small. Typically, release of information about a specific demographic subgroup in a geographic area requires a numerator of at least 5 and a denominator of at least 100. Proposed analyses where the numerator or denominator is small, approaching the limits above should be discussed with the Section Chief to determine if release is warranted and appropriate.
- Staff should always use caution regarding the following analysis categories when cross tabulating to prevent inadvertent identification:
    - Infrequent race/ethnicity categories such as Hawaiian or Alaska Native.
    - Transgender or other infrequent gender categories.
    - Small or single-year age groups.
    - Infrequent risk behavior categories (e.g., perinatal, needle stick).
    - Small geographic areas.

- Use of GIS Mapping (minimum standards)
    - If PII will be used in GIS analysis, precautions must be taken to protect confidentiality.
    - Addresses and their equivalent latitudes and longitudes are identifiers and must be safeguarded using the same methods used to safeguard names.
    - Results of GIS analysis must not be released in the form of spot maps (where single cases are represented as dots) or other maps that could be identifying.
    - Care must be taken that use of demographic (age, race, gender) or behavioral subsets (MSM, IDU), which may be used to select cases for analysis, does not lead to identification.

- When the analysis product is completed and ready to be sent to the customer, Program Managers should seek approval from the appropriate Section Chief to ensure that potentially identifying information is not disclosed.

LEGAL AUTHORITY FOR DATA SHARINGAND RELEASE

Local health departments (LHDs) are legally able to release individual case information for STIs, TB and viral hepatitis containing PII under certain conditions (K.S.A 65-118). Under K.S.A. 65-6002, KDHE has legal authority to release HIV case information under certain condition. The Secretary of Health and Environment can also release the information if the county board or health or local health officer fails to do so.

4.0 PHYSICAL SECURITY

BUILDINGS / OFFICES

- All PII, electronic and paper, must be maintained in a secure, locked area with limited access. A secure area is an area which is protected by at least one level of physical security.
- Rooms containing PII or where PII is viewed should not have windows. If the room does have windows, PII must not be able to be viewed from outside the window.
- Keys, and key-cards enabling access to secure areas must not be shared or loaned.
- All visitors to the BDCP must sign in, wear a visitor's badge
- If visitor is a non-KDHE employee they must be escorted by a BDCP employee until they reach their destination and when they travel through the BDCP Suite.
    - Visitors are defined as:
        - Any person who is not a KDHE employee or;
        - KDHE employees whose key card does not give them access to the BDCP Suite.
        - Exceptions include employees from Department of Administration and Department of Facilities Management who have key card access to the BDCP Suite.
- Persons with authorized access to BDCP must be able to identify visitors (e.g. Identification badge) and adjust behaviors accordingly.
- Secured doors should not be propped open or disabled unless prior approval to do so has been obtained from the ORP.
- A dedicated, secure room is the preferred location for PII.

COMPUTER WORKSTATIONS

- All computer workstations with access to confidential information must be in a secure area.
- Computer screens must not be readily observable by non-authorized users as they pass through the office area, work within the Bureau Suite, or approach reception areas. Security screens may be installed on computer monitors to prevent viewing of information on the computer screen by anyone other than the assigned operator.
- Computers used to access PII must be password protected at the Windows login level, and have a password protected screensaver program installed and activated.
- All network/computer passwords must follow current KDHE password guidelines.
- Network/computer passwords expire based on current KDHE password guidelines.

- New or temporary passwords issued to a staff member must be changed upon receipt of the password.
- Computer passwords must not be shared with others.
- No one should access a computer or network using another person's access.
- If a password's security is in doubt, it must be changed immediately.
- Passwords should not be written down.
- Computer workstations must be locked (Ctrl/Alt/Delete - Lock Workstation) when a workstation is left unattended even for short periods of time.
- Confidential data must not be accessed or worked with on any computer or mobile device that is not KDHE issued.

DOCUMENT DISPOSAL

- Documents containing PII must be shredded with crosscutting shredders before disposal or placed in designated shredding disposal bins. Crosscutting features are needed to ensure confidential information cannot be recovered.
- Individual sections shall determine the duration of storage of paper documents. (Appendix 2 Long Term Storage)
- Other duplicated confidential data must be shredded or erased electronically when no longer needed.
- Electronic media (diskette, CDs, DVDs, etc.) must be shredded with a crosscutting shredder or sent to OITS for disposal.

DOCUMENT STORAGE

IN THE OFFICE / IN SECURE AREAS

- When not in use, all documents with PII must be stored with two levels of security.
- PII must not be left unattended in any place or area to which unauthorized persons may reasonably gain access.
- Documents with confidential information must not be readily observable by unauthorized users as they pass through the office, use workstations, or approach reception areas.
- When documents with confidential information are taken from a secured area they must be transported in a secure, sealed manner.

OUTSIDE THE OFFICE / OUTSIDE SECURE AREAS

- Transportation and use of PII outside of secure areas shall be minimized and carefully controlled.
- When possible, it is preferred that documents removed from secure areas not contain both identifiable information and disease-specific information.
- Clients should not have access to other client's PII.
- During an investigation, confidential information must not be taken to a private residence, place of business, or any other location, other than the client's residence (and only those documents relevant to that specific client).
- When documents with PII are taken from a secured area to the field they must contain the minimum amount of confidential information necessary to do business.
- The contents of the files will not be divulged to any unauthorized persons. They will be carried in a manner as to prevent easy viewing and protected from easy theft or loss
- All documents containing PII must be returned to a secure environment by the close of business each day unless prior approval has been received, and the employee is in possession of appropriate means of securing the information as outlined above.

MAIL (INCOMING AND OUTGOING)

- Incoming mail marked "Confidential" or addressed to HIV/AIDS, Immunizations, STI, or TB programs shall be opened only by approved and assigned staff and kept secure until processed.
- Senders of confidential information are instructed to address mail to the appropriate program.
- Whenever confidential information is mailed, double envelopes or the equivalent must be used, and sent "Return Service Requested".
- No outgoing mail to individual patients or clients should have any direct reference to HIV/AIDS, Immunizations, STI, or TB.

MAIL HANDLING POLICY

- The assigned staff person and assigned alternates will collect the mail from the basement on a set schedule. The schedule for collection will be posted in the mail room for everyone to view. The person who picks up the mail will be responsible for distributing mail to the appropriate boxes in the mailroom as the following details below.

- The weekly schedule will assign one person each day to deliver/pickup at 10:30 AM and 2:30 PM. Each person is responsible for delivering and picking up new mail on their assigned day.
- If the person scheduled for pick-up is out sick or is otherwise unavailable that day, the alternate will be responsible for mail pick-up and delivery.

- When a primary or alternate mail handler leaves Bureau service, the Section Chief for that section will assign a new staff person to fill the role.

- Each Section Chief in the BDCP as well as the Bureau Director (ORP) will have his or her individual mailbox in the BDCP mailroom.
- Each programmatic section within the bureau will have a group mail basket so labeled. Each section will designate a person to collect the mail from their group box and disseminate it to the proper individual within their section.
- Incoming mail assigned to employees who have since left the Bureau shall be presented to the ORP for final dissemination.

SPECIAL HANDLING OF LABORATORY REPORTS

- Mail assigned to the "Laboratory Reports" basket in the mailroom will be opened and routed by one assigned individual (primary) and one assigned back-up person.
- For HIV and STI laboratory reports, the selected person will be responsible for delivery of the laboratory reports to the appropriate basket located in the Central Office immediately upon opening.
- For TB laboratory reports, the selected person will be responsible for delivery of the laboratory reports to the appropriate basket located in the mailroom immediately upon opening.
- This will ensure that all labs are opened and delivered in a timely manner, and bring to the attention of someone in the responsible section the nature of the report. This should eliminate labs from being placed in the wrong mailbox, or on a desk when the recipient is out of town.

PHONE

- Telephone calls concerning PII must be made in a secure area. If possible, telephone calls concerning PII should be made in an area where conversations cannot be overheard.

- Staff must reasonably ascertain that phone contacts are legitimate before discussing confidential information on the phone.
- Staff will only share the appropriate amount of confidential information needed.
- Confidential information may only be left on secured voicemails.
- KDHE VOIP is confidential and if PII is left on voicemail, then it is not a breach of confidentiality.

5.0 ELECTRONIC DATA SECURITY

ELECTRONIC DATASETS AND STORAGE

- Analysis datasets that can be accessed from outside the secure area shall be stored with protective software (i.e., software that controls data storage, removal, and use) and removal of all personal identifiers shall be verified.
- At a minimum, analysis datasets shall be located on a virtual server and all personal identifiers shall be removed. The inclusion of sensitive or potentially linkable data elements such as lab ID, lab accession number, medical record number, or case report number shall be limited to those required for analysis and shall not be included in analysis datasets.

ELECTRONIC DATA TRANSFER

- Electronic transfer of data shall be approved by the SAC and is subject to access controls.
- Designated BDCP staff are allowed to send encrypted data after approval by the Section Chief.
- Identifiable data shall be encrypted using an encryption package that meets the Advanced Encryption Standard (AES) before being transferred. This applies particularly to situations in which data are obtained electronically from sources outside KDHE (e.g. electronic laboratory data, electronic health records, web-based systems, hospitals, local health departments, and other large providers). Extracts from these systems shall meet the minimum security standards as outlined in this document. Electronic records shall be protected through security devices such as sign-on passwords, encryption, and audit trails. External sources shall be encouraged to review their procedures. Approved data transfer methods shall be used when designing electronic reporting mechanisms for laboratories, providers, etc.
- Data shall be encrypted during data transfers and

- Shall be transferred over a secure data network (SDN) or virtual private network (VPN) connection with certificates on both the sending and receiving ends, or similar secure network
- If a SDN or VPN cannot be used, then it shall be transferred via a secure application such as a file transfer protocol (FTP) for which certification is required on at least one end.

All staff that have authorized access to confidential information are individually responsible for protecting their assigned laptop or other portable devices including, but not limited to: cell phones, tablet, laptops, flash drives, diskettes, CD-ROMS, zip disks, tape backups, removable hard drives, and/or smart cards.

MOBILE DEVICES (CELL PHONE, TABLET) AND LAPTOPS

- Laptops used as a work computer follow the same security and confidentiality guidelines as workstations (refer to Physical Security Section).
- Laptops and mobile devices shall not be left accessible in non-secure areas.
- Laptops and mobile devices shall be stored in a secure area when not in use.
- PII on a laptop must be encrypted according to AES and stored on an external storage device or removable hard drive. The external storage or removable hard drive must be separated from the laptop and must be locked up or stored in a locked file cabinet when not in use.
- Mobile devices and laptops without external storage devices or removable hard drives must have encryption software that meets AES.

EXTERNAL STORAGE DEVICES AND REMOVABLE HARD DRIVES

All external storage devices and removable hard drives containing PII data must:

- Include only the minimum amount of information necessary to accomplish assigned task as determined by the designated official or ORP
- Be encrypted according to AES
- Locked up or stored in a locked file cabinet when not in use
- All PII must be erased immediately following a given task (except for those used as back-ups) by designated BDCP staff or OITS.

E-MAIL

- If confidential information is sent via e-mail transcription, it must be sent as an encrypted attachment and contain the minimum data necessary. The encryption software used must meet AES and be approved by the SAC.
- If PII is sent non-encrypted, the ORP must be notified. Do not forward the email onto the ORP. Inform the sender that the PII has been sent non-encrypted and do not reply to the email containing the non-encrypted PII.
- E-mailing of PII is not allowed.

FAX (INCOMING AND OUTGOING)

- Facsimile transmission of confidential information must only be done when other methods of sending information are unavailable or would delay the timely provision of services.
- When a fax is necessary, it should be ensured that the minimum amount of confidential information is included.
- Fax machines must be located in secure areas.
- All fax communications containing PII must be sent with a cover sheet that includes name and contact information of the sender and the recipient, confidentiality disclaimer statement, and instructions on what to do if the document is received in error (see Sample Confidentiality Disclaimer below).
- Anyone sending a fax must confirm that the information faxed was received by the intended recipient.
- If a fax transmission fails to reach the recipient, the internal logging system of the fax machine shall be checked to obtain the number to which the transmission was sent. If the sender becomes aware that a fax was misdirected, contact the receiver and ask that the material be destroyed. Misdirected faxes shall be investigated as a potential security breach, the ORP shall be informed, and the incident logged for remediation/mitigation.

Sample Confidentiality Disclaimer*: *The documents accompanying this fax transmission contain health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.*

* Based on “Facsimile Transmission of Health Information”

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_031811.hcsp?dDocName=bok1_031811

STATEMENT FOR PROTECTION OF CONFIDENTIAL INFORMATION

1. I have read and understand "Data Security and Confidentiality Policy" for this Bureau (BDCP) and accept the obligation to protect confidential information in a manner consistent with these policies and procedures.

2. I understand that protecting confidential information is a public trust, and that unauthorized disclosure of confidential information not only threatens the ability of this agency to serve the public, but is a violation of Kansas Statute Annotated 75-2949f, et al.

3. I understand that the unauthorized disclosure of confidential information, whether by negligence or intent, may result in disciplinary action, including dismissal as outlined in K.S.A. 75-2949 d & f, n, and/or criminal prosecution.

Type or Print Name_____

Signature and Date_____

PLEASE KEEP ORIGINAL AND GIVE COPY TO EMPLOYEE

APPENDIX 1 LIST OF ROLES, SYSTEM ACCESS, AND LEVEL

STI / HIV

Role	EDSS	EDSS ELR	eHARS	eHARS ELR	SCOUT	STD*MIS	Lab Reports (Fax / Mail)	LIMS	Access Level

Access Level									
X = Standard									
L = Limited Access (limited to a specific directory where files can be exchanged with the server)									
A = Administrative Access									
*A = Access Limited. Account activated by appointed Department of Health staff.									
LL = Limited Access									
** = No Longer Active									

TB

Role	EDSS	EDSS ELR	TIMS	TB Legacy Data	Lab Reports (Fax / Mail)	LIMS	Access Level
Access Level							
X = Standard							
L = Limited Access (limited to a specific directory where files can be exchanged with the server)							
A = Administrative Access							
*A = Access Limited. Account activated by appointed Department of Health staff.							
LL = Limited Access							
** = No Longer Active							

Role	WebIZ	Immunization Records	Access Level
Access Level			
X = Standard			
L = Limited Access (limited to a specific directory where files can be exchang			
A = Administrative Access			
*A = Access Limited. Account activated by appointed Department of Health s			
LL = Limited Access			
** = No Longer Active			

APPENDIX 2 LONG TERM STORAGE

The Kansas State Records Center provides centralized, efficient, and secure storage for inactive and semi-active state government records. Authorized by the legislature in 1957 and funded in 1992, the State Records Center offers agencies controlled access to their records until administrative, fiscal, and legal retention requirements are met.

There are several advantages to using the State Records Center. Agencies will save money by transferring materials to the state records center in a timely fashion, thereby freeing up prime office space for more active use and reducing the need to purchase additional high cost filing equipment. The state records center provides control of records in a clean, well-lit structure which eliminates the use of attics, sub-basements or similar inadequate storage areas. Finally, and most beneficial, staff will no longer have to devote valuable time to extensive searches through cramped storage areas for semi-active and inactive files. The State Records Center offers prompt and courteous document retrieval within 24 hours. While the state records center is administered by the Library and Archives Division of the Kansas Historical Society, it is separate from the State Archives, which houses the noncurrent state and local government records with enduring value. The state records center and the state archives cooperate to insure the proper management of the state's valuable records and information resources.

The records center is located at 2331 NW Furman Road, telephone number 785-232-1123; Fax 785-232-9330. Hours of operation are 8 a.m.- 5 p.m., Monday - Friday.

USING THE STATE RECORDS CENTER

In order to store records at the state records center:

- The agency must have both a completed records survey and a retention and disposition schedule approved by the State Records Board. If these are not in place or if the schedule needs revising, contact the state records manager at 785-272-8681 about setting up a time to do so.
- Only semi-active or inactive records will be stored in the state records center. Records are considered semi-active or inactive when an agency refers to them less than once a month.
- The agency must have an assigned records officer as specified in K.A.R. 53-4-1. This person is the liaison between the agency and the Historical Society. Responsibilities of records officers include, but are not be limited to, the following:
  - Obtaining storage boxes and forms from the state records center.
  - Supervising the placement of records in the boxes and completing all forms necessary for the transfer of records. Agency indexes or finding aids should be included whenever possible.
  - Labeling and numbering the boxes.

- Providing an Authorization for Access list of personnel who are allowed to request agency records stored at the records center.
- Communicating with the state records center staff as needed.

All records are property of the state (see K.S.A. 45-403), but the agency retains custody of their records stored in the state records center. The State Archives becomes custodian of any records transferred from the state records center to the state archives.

K.S.A. 75-3511 prohibits the use of state agency records stored at the state records center without the approval of the originating agency. In accordance with this statutory requirement, the state records center will protect the agency's records from unauthorized access by allowing only individuals with written permission to request records. An Authorization for Access form will be sent to all agencies and only those included on the list will be granted access. If someone is not on the list and needs access, a letter from the records officer noting the effective period of authorization will be acceptable. The public will not be allowed to use the records center for research.

TRANSFERRING RECORDS

REQUEST BOXES

The first step in transferring records is to contact the state records center staff and request the necessary boxes. Only standard sized cartons will be accepted. Odd size boxes do not fit on the shelves properly which wastes space and defeats the purpose of providing efficient and economical storage. The standard size box is 12" wide x 15" long x 10" high and will accommodate one cubic foot of material. These cartons will store both letter and legal size files. (See the table below to calculate the number of boxes needed.) There is no charge to agencies for the boxes when used for sending records to the Records Center. Requests for additional cartons will not be honored until all previous allotments are accounted for.

Cubic Foot Equivalents

- 1 letter-size file drawer = 1.5 cu. ft. or 2 boxes
- 1 legal-size file drawer = 2.0 cu. ft. or 2 boxes
- 1 letter-size, 36" open shelf file = 2.0 cu. ft. or 2 boxes
- 1 legal-size, 36" open shelf file = 3.0 cu. ft. or 3 boxes
- 3" x 5" cards, ten 12" rows = 1.0 cu. ft. or 1 box
- 4" x 6" cards, six 12" rows = 1.0 cu. ft. or 1 box
- 5" x 8" cards, four 12" rows = 1.0 cu. ft. or 1 box

PACK BOXES

Upon receipt of the cartons, observe the following guidelines to properly pack the boxes:

- It is strongly suggested that a box be limited to just one record series. If it is necessary to place multiple record series in a box, the carton should be limited to records with the same retention period and disposition requirements.
- Files in a record series should be cut off periodically to ease the transfer of records in uniform chronological blocks. This is referred to as "breaking" files and means that on a given date a new set of files is established for the following period. Files can be broken annually, biennially, or at longer intervals depending upon the rate of accumulation. The time frame for breaking a records series may depend upon the occurrence of an event such as the termination of a contract or benefit. Using color coded folder labels can be helpful in distinguishing periods.
- When packing the boxes, leave the records in their original order and file folders. Make sure that the folders are clearly labeled. The records center staff must be able to locate a single file within a box, and they will not be familiar with the records.
- Be sure that the file folders are not too full. Ideally, folders should be limited to 25 pages and they should never contain more than 50 pages.
- Please do not put hanging file folders in the boxes--the lid will not fit properly. Place all documents (with the exception of oversize materials) in accurately labeled standard file folders.
- Place letter size records in the box facing the front. Place legal size records in the box sideways starting from left to right. Stack computer printouts and ledgers flat, but do not stack them past the hand-holes.
- Do not overfill boxes--there should be room to remove files without difficulty. If the cartons are too full the lids will not fit securely, the boxes will not fit on the shelving, the box sides and bottoms will tear, and the possibility of damage to the records increases.
- Make sure that all box hand hole cutouts are pushed in.
- Notify the staff of any oversize materials ahead of time.
- Records that are up for disposition before the next fiscal year need to be retained by the Agency until disposed of.

COMPLETE RECORDS TRANSFER FORM

An agency seeking to transfer materials to the state records center must complete a Records Transfer form. It serves as a shipping manifest, receipt, and retrieval tool. The state records manager will review the completed transfer forms for accuracy. The following information should be typed or printed on all Records Transfer forms:

- **Agency Code:** Enter the appropriate three digit agency code number. (Agency codes are listed in the Communication Services Directory.)
- **Telephone Number:** Enter the telephone number for the records officer.
- **Date:** Enter the current date.

- **Agency/Division/Other Organizational Unit:** Enter the name of the agency, the division, and any other organizational unit necessary for complete identification.
- **Agency Address:** Enter the full mailing address for the agency/division and other organizational unit.
- **Records Officer or Transferred By:** Enter the name of the records officer or the individual authorizing the records transfer.
- **Restrictions:** Check the appropriate yes or no box.
- **Type of Final Disposition:** Using data from the agency retention/disposition schedule, indicate whether the records will be destroyed or transferred to the State Archives when the disposition date has been reached. Please DO NOT include records with different final disposition requirements on the same Records Transfer form.
- **Agency Box Number:** Enter the agency box number for each carton being transferred. Boxes should be numbered sequentially.
- **Records Series Number and Records Series Title:** Use the record series title(s) and record series number exactly as they appear in the agency retention/disposition schedule and the inclusive dates of the records. Retrieval service will be facilitated if the box content description includes the numerical or alphabetical coverage of the records in the carton.
- **Disposition Date:** Use information from the agency retention/disposition schedule to determine the disposition date for the records being transferred; enter the date in "year/month" format.

Please submit the completed Records Transfer form to the records center manager for review. Incomplete or incorrect forms will be returned to the records officer for verification of information. Once the form is approved, Records Center staff will contact the Agency to schedule the pick-up.

The records center manager will assign a unique records center location number to each box. The original white transfer form is retained by the records center manager. The yellow copy is sent to the records officer and the pink copy goes to the office sending the records. Both copies returned to the agency will have the records center location number so it is important to keep the forms for future reference. The records center location number will be used to request files or boxes from the state records center.

Transfer Form available upon request, contact Matt Veatch at:

Kansas Historical Society
6425 SW 6th Avenue
Topeka KS 66615-1099
785-272-8681, ext. 271
FAX 785-272-8682
email: mveatch@kshs.org

LABEL & NUMBER BOXES

Agencies must label and number all boxes prior to their transfer to the state records center. Using data from the Records Transfer form, print the following information under the handle on the center of the box:

- Agency/Division/Other Organizational Unit
- Description of Records
- Disposition Date
- Disposition

With a black permanent marker, number the boxes in the correct sequential order on the upper left hand corner of the carton.

It is essential that the box numbers shown on the transfer form correspond exactly with the numbers written on the cartons.

SCHEDULE RECORDS PICK-UP

Once the transfer has been accepted, arrangements need to be made for the state records center staff to pick up the cartons ready for transfer. Agencies outside the Topeka area will be responsible for any transfer arrangements. On the day scheduled for pick up by the state records center staff, the boxes need to be stacked at the loading dock five boxes high.

AUTHORIZING ACCESS TO RECORDS

Agencies must complete an Authorization for Access form to designate the individuals who will be allowed access to records stored at the state records center. Only persons appearing on this form will be given access to the agency's records. This policy applies to both written and telephone requests for records.

If an individual who is not listed on the Authorization for Access form needs access to agency materials at the state records center, the records officer must send an authorization letter to the records center manager. The letter must specify the effective period of authorization.

Authorization for Access form available upon request, contact Matt Veatch at:

Kansas Historical Society
6425 SW 6th Ave.
Topeka, KS 66615-1099
785-272-8681, ext. 271

FAX 785-272-8682
Email: mveatch@kshs.org

REQUESTING RECORDS

To request records, personnel authorized for access by the agency need either to complete the Records Request form and fax or e-mail it to the state records center. In the latter case, state records center staff will complete the form for proper documentation. Only factual information from records--names, dates, amounts--will be provided over the telephone. Requests for five pages or less can be returned to the agency via fax. The telephone number for the records center is 785-232-1123. The records center fax number is 785-232-9330.

Records are pulled at the time of the request. In most cases, requests received before 8:00 a.m. will be delivered that morning, while those received after 8:00 a.m. will be delivered the following morning. State records center staff will hand deliver all materials unless the agency makes other arrangements.

Agency staff will use the transfer form to determine the records center location number to provide the records center staff with the exact box number that contains the needed file. Be as specific as possible when requesting a file including the record series title, file name, records center location number, date of record, and the storage medium.

Files should be returned to the state records center as soon as they are no longer needed. They should not be allowed to accumulate. Material can be returned through the central mail system to KSHS or the records center staff can be notified to pick up the records. Prompt return will insure that files are refiled quickly and accurately. Refile reminder notices will be sent to agencies only for files that are scheduled for transfer to the State Archives. This helps maintain the integrity of the records series with enduring value.

If agency personnel (or an auditor) require access to large quantities of records and it would be more convenient to work in the state records center, work space will be provided. Agency personnel visits to the state records center must be arranged in advance and identification must be provided. The public will not be allowed to use the state records center for research.

RECORDS DISPOSITION

Unless otherwise notified, records will be destroyed or transferred to the State Archives according to approved retention and disposition schedules. Thirty days before destruction or transfer, the records center manager will send the agency records officer a Records Disposition report. If the agency wants its records retained in the state records center beyond the approved disposition date, the records officer must notify the Records Center within 30 days of receipt of disposition report.

DESTRUCTION METHOD

Recycling is the preferred method of destruction. Confidential records are shredded at agency expense by the state contracted shredding firm. A Records Destruction Certificate will be sent to the agency after confidential materials have been shredded. If the agency desires, a representative from that agency may send someone to witness the destruction of any confidential records.

SECURITY MICROFILM STORAGE

The Records Management Section also offers storage of microfilm security negatives to encourage the protection and preservation of vital and historical records. The agency needs to fill out a Records Transfer form and notify the state records center to arrange the transfer.

RECORDS MANAGEMENT TRAINING

Other records management services include training sessions on basic records management techniques; using the records center; records surveys and retention and disposition schedules; and the role of records officers. Contact the state records manager for more information at 785-272-8681, ext. 288.

For a listing of the Retention/Disposition Schedule see the Overall Responsible Party (ORP).

Kansas Department of Health and Environment

Bureau of Disease Control and Prevention (BDCP)

Security Advisory Council (SAC) Procedural Guidelines

For HIV, Viral Hepatitis, Sexually Transmitted Infection, Tuberculosis and

Vaccine-Preventable Disease (Immunization) Programs

Standards to Facilitate Sharing and Use of Surveillance Data for Public Health Action

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ACRONYMS

AES – Advanced Encryption Standard

BDCP – Bureau of Disease Control and Prevention

CDC – Centers for Disease Control and Prevention

DSA – Data Sharing Agreement

FTP – File Transport Protocol

HIV – Human Immunodeficiency Virus

IRB – Internal Review Board

KDHE – Kansas Department of Health and Environment

MOA – Memorandum of Agreement

PII – Personally Identifiable Information

OITS – Office of Information Technology Services

ORP – Overall Responsible Party

SAC – Security Advisory Council

SDN – Secure Data Network

STI – Sexually Transmitted Infections

TB – Tuberculosis

VPD – Vaccine Preventable Disease

VPN – Virtual Private Network

SECURITY ADVISORY COUNCIL PROCEDURAL GUIDELINES

OVERALL RESPONSIBLE PARTY

The overall responsible party (ORP) for the security of public health data in BDCP shall be the BDCP Bureau Director. The ORP shall be responsible for any public health data that BDCP collects or maintains. The ORP shall further be responsible for establishing and maintaining a Security Advisory Council (SAC). The SAC shall be chaired by the ORP and contain representatives from each of the sections within BDCP.

Members of the SAC include:

- BDCP Director
- Deputy BDCP Director
- TB Section Chief
- STI/HIV Section Chief
- Immunization Section Chief
- STI/HIV Surveillance Program Manager
- Manager, KDHE Computer Support

ASSURING COMPLIANCE WITH SECURITY & CONFIDENTIALITY POLICIES

The SAC will, at a minimum, verify compliance with CDC's Data Security and Confidentiality Guidelines annually. This verification will be scheduled to occur February of each year unless altered by the SAC. The SAC will also review the BDCP Security and Confidentiality Policy and Access Logs for update at this time.

During this established review period (February-February), breaches of confidentiality will be reviewed and analyzed to determine any areas for improvement in existing policies and procedures to prevent future occurrences.

ONGOING REVIEW OF TECHNOLOGICAL ASPECTS OF SECURITY AND CONFIDENTIALITY

Technological aspects of Security and Confidentiality will be handled in accordance with KDHE internal directive 7002.0 "Kansas Department of Health and Environment Information Technology Security Policy". In the event that a technology issue is identified not currently stipulated in the internal directive, the specifics will be given to the Manager of KDHE Computer

Support for investigation and clarification from KDHE's Information Technology (IT) Department.

In accordance with KDHE policy, computer equipment will not be sent to an outside vendor for repair or replacement with the hard drive or other storage media installed. Before sending hardware in for repair or replacement, the hard drives or storage media will be removed and secured by KDHE IT staff. Additionally, all hard drives, (including those in copiers, printers, scanners, etc.) will be removed by KDHE's IT Department before being sent for disposal.

In accordance with KDHE policy, iPhone devices and other cellular devices will not be sent to an outside vendor for repair, replacement, or electronic recycling before they are completely wiped of all information. Storage media will be removed from these devices prior to them being shipped to an outside vendor.

SECURITY AND CONFIDENTIALITY TRAINING

All training records shall be maintained by the STI/HIV Surveillance Program in a location available to all members of the SAC. All signed Security & Confidentiality statements shall be maintained by the STI/HIV Surveillance Program in a location available to all members of the SAC. The STI/HIV Surveillance Program shall ensure that all newly hired BDCP employees (or non-BDCP employees with access to BDCP PII) receive Security & Confidentiality training and sign Security & Confidentiality statements. The STI/HIV Surveillance Program shall review with the ORP prior to the annual SAC meeting the list of individuals granted physical access to BDCP to ensure access is still appropriate, and to verify that annual statements are received from all identified individuals.

Training requirements are outlined below:

NEW BDCP EMPLOYEES

- All newly hired staff members must receive and successfully pass Security and Confidentiality training through KS-TRAIN within one week of hire.
- All newly hired staff members must sign a confidentiality agreement which will be kept on file by the ORP within one week of hire.
- All KDHE staff members must receive generic security awareness training upon hire at KDHE's New Employee Orientation. Documentation of this training shall be kept in each employee's personnel file within Personnel Services.

ALL BDCP EMPLOYEES

All BDCP staff must receive annual Security and Confidentially Training in September of each year. Training will cover:

- Personal responsibilities
- Procedures for ensuring physical security of PII
- Policies and procedures for data sharing
- Procedures for reporting and responding to security breaches
- Review of relevant laws and regulations

After annual training, all BDCP staff will re-sign a confidentiality agreement and verify that they attended the annual training.

KDHE STAFF (NON BDCP)

All KDHE (non-BDCP) staff who have access to BDCP PII shall receive annual security and confidentially training. Training will be based on this document and will cover:

- Personal responsibilities
- Procedures for ensuring physical security of PII
- Policies and procedures for data sharing
- Procedures for reporting and responding to security breaches
- Review of relevant laws and regulations

After annual training, staff shall re-sign a confidentiality agreement and verify that they attended the annual training. This document will be kept on file by the ORP.

EXTERNAL PARTNERS (PROGRAMS, BUREAUS, AGENCIES, ETC.)

External partners are defined as entities outside of BDCP with whom data must be shared in order to fulfill the public health duties of the bureau. This may include other programs or bureaus within KDHE, other state agencies, and/or contractors of KDHE.

- All external partners will sign a confidentiality agreement which will be kept on file by the ORP.
- All external partners will receive program specific security and confidentiality training annually.

BREACH OF SECURITY AND/OR CONFIDENTIALITY

BREACH OF CONFIDENTIALITY INVESTIGATION PROCESS

An internal breach of confidentiality is defined as: Disclosure of BDCP confidential information to: 1) any person outside BDCP who lacks legal right of access, or 2) to BDCP employees who do not need access to the information for completion of assigned duties.

An external breach of confidentiality is defined as: Disclosure of PII or confidential information from someone outside of BDCP to someone within BDCP without proper cause or without following appropriate protective measures (i.e. encrypting files in email, etc.).

All staff are required to immediately notify their supervisor, Section Chief, and the ORP of any breach of security and/or confidentiality. Once notified of the breach, the ORP will notify all members of the SAC of the mechanics of any internal breaches, without divulging any personnel information (employee name, position, etc.). Any breach that involves the disclosure of PII will be referred to legal counsel to determine if law enforcement should be contacted. Documentation of all breaches will be maintained by the **ORP** (or ORP's designee) in an area accessible to all members of the SAC, describing the investigation findings and corrective actions taken.

BREACH CONSEQUENCES AND FOLLOW-UP

External breaches require no follow-up beyond notification of the originating entity that security and/or confidentiality has been breached along with information on BDCP policies.

Internal breaches that are intentional will be immediately referred to the Office of Personnel Services to begin potential termination proceedings.

Internal breaches that are unintentional will be evaluated by the SAC on a case-by-case basis to determine: 1) damage caused as a result of the breach 2)remediation measures to be taken.

DATA SHARING

DATA SHARING OUTSIDE BDCP

For individual cases, data may be shared without written agreements with local health departments, health care providers, and other KDHE programs if there is a public health need.

For all other situations where data sharing (datasets) is requested, written agreements must be established prior to data sharing. The written agreements will be developed and approved by the SAC.

- Memorandum of Agreement (MOA) – internal; other disease programs within KDHE
- Data Sharing Agreement (DSA) – external; LHD, university, NGO, research, etc.

DATA SHARING WITHIN BDCP

Information about reportable conditions can be exchanged freely between all programs within BDCP authorized to conduct surveillance for those conditions as necessary for public health purposes.

DATA RELEASE

Standing data agreements are defined as agreements with entities outside of BDCP to provide PII data at regularly scheduled intervals (usually consists of individual-level identifiable data). These agreements must be approved by the SAC initially, and at any time that data sharing/data release policies change. The SAC will maintain a list of approved standing data agreements identifying entity receiving information, description of data, schedule of data release, any restrictions or guidance on the release, and date of approval. Data agreements are not required for generalized, aggregate data that has been approved by the respective Section Chief as outlined below.

Ad-hoc aggregate data requests must receive approval from the appropriate Section Chief to ensure that potentially identifying information is not disclosed. Section Chiefs are responsible for ensuring that data is not individually identifiable and does not contain small cell sizes (less than 5 for cross-tabulated data). If the Section Chief is unclear or uncertain about the appropriateness of the data release, the SAC shall be consulted.

Data requests that contain PII or potentially identifiable information must be approved by the SAC. The SAC is responsible for ensuring that the minimum possible data elements are being requested for the purpose of the data request, that the requesting entity has security & confidentiality measures equivalent to (or more restrictive than) BDCP policy, and that a data-sharing agreement is in place prior to the release of the data.

Kansas Department of Health and Environment
Bloodborne Pathogens
Exposure Control Plan

March 2007

Kansas Department of Health and Environment

Bloodborne Pathogens Exposure Control Plan

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Kansas Department of Health and Environment Bloodborne Pathogens Exposure Control Plan

Introduction

In March 1992, Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogen Standard, 29 CFR 1910.1030 took effect. Revisions were published January 18, 2001 to the "Federal Register's Occupational Exposure to Bloodborne Pathogens; Needlestick and Other Sharps Injuries; Final Rule. - 66:5317-5325 (Appendix A). The standard was designed to reduce occupational exposure to blood and other potentially infectious materials (OPIM), resulting in the prevention of more than 200 deaths and 9,000 bloodborne infections every year. While the standard was primarily aimed at hospitals, funeral homes, nursing homes, clinics, law enforcement agencies, emergency responders, and HIV/HBV research laboratories, anyone who can "reasonably expect to come in contact with blood or other potentially infectious materials" as part of their job is covered by the standard. In Kansas, the Kansas Department of Labor, Division of Industrial Safety and Health administers the program requirements for compliance with OSHA Bloodborne Pathogen Standard. The **Exposure Control Plan** requires employers to identify, in writing, tasks and procedures as well as job classifications where occupational exposure to blood occurs--without regard to personal protective clothing and equipment. It must also set forth the schedule for implementing other provisions of the standard and specify the procedure for evaluating circumstances surrounding exposure incidents. The plan must be accessible to employees and available to OSHA. Employers must review and update it at least annually--more often if necessary to accommodate workplace changes.

PURPOSE & SCOPE

Purpose: Limit occupational exposure to blood and other potentially infectious materials since any exposure could result in transmission of bloodborne pathogens that could lead to disease or death.

Scope: Cover all employees who could be "reasonably anticipated" as the result of performing their job duties to face contact with blood and other potentially infectious materials (OPIM). A list all occupations where exposures could occur has not been developed by OSHA. Incidental "Good Samaritan" acts such as assisting a co-worker with

a nosebleed would not be considered occupational exposure and, therefore, such acts are not subject to the provisions of the Exposure Control Plan.

MANAGEMENT

The five groups involved in the management and maintenance of the Exposure Control Plan include the Exposure Control Plan Committee, the Safety Officer, the Division of Management and Budget (DMB), managers and/or supervisors of employees who can be "reasonably anticipated" to have exposure to blood and other potentially infectious materials, and employees functioning in those jobs and positions with duties that involve anticipated exposure to blood and other potentially infectious materials.

Exposure Control Plan Committee. The committee is composed of the following individuals or their designated representative:

- State Epidemiologist
- Director of the Division of Health
- Director of the Division of Environment
- Director of the Kansas Health and Environmental Laboratory
- Safety Officer, Kansas Health and Environmental Laboratory
- Director of Human Resources, Division of Management and Budget
- Organizational Development, Division of Management and Budget
- Kansas Department of Labor, Division of Industrial Safety and Health

Appointment of such a designee should take into consideration the need for continuity on the committee.

The Exposure Control Plan Committee responsibilities are to:

- Develop the plan and obtaining approval of all policies and procedures from the Secretary of Health and Environment
- Review and revise the Exposure Control Plan at least annually
- Update the plan as needed – when new OSHA regulations need to be added to the plan

    - New positions are established, new tasks implemented that affect occupational exposure for employees, and/or when new departments are added that may involve procedures having occupational exposure to bloodborne pathogens

- Assist supervisors in auditing their employees for compliance with the plan
- Review evaluations of sharps injury protective devices, and exposure incidents for the development of engineering controls and work practices needed to reduce incidents
- The Secretary of Health and Environment will review, sign, and issue the plan to all divisions affected by the plan.

Safety Officer (SO), Kansas Department of Health and Environment. The SO responsibilities are to:

- Act in the capacity of the safety compliance officer ensuring the implementation of the Exposure Control Plan
- Will support the review of the plan for annual and intermittent revisions as indicated through changes in personnel, program duties and responsibilities, or Kansas occupational health and safety requirements
- Serve as the subject matter expert to assure compliance with occupational requirements

Division of Management & Budget's Human Resources and Organizational Development - Human Resources responsibilities are to:

- Provide oversight on plan development and maintenance
- Act as the agency liaison during Kansas Department of Labor, Division of Industrial Safety and Health administers inspections
- Assist supervisors as needed in classifying each of their employees regarding potential occupational exposure
- Assure that position descriptions reflect the exposure classification
- Maintain employee records for compliance with BBP exposure control plan, exposure incident reports and follow-up
- Compile and maintain a list of position numbers and titles by exposure classification
- Compile and maintain a list of job duties and/or skills that place the position into specified exposure classification

- Obtain and maintain relevant contracts with health care providers
- Provide access to the agency's most current exposure control plan

Organizational Development responsibilities are to:

- Coordinate review of methods and content of training program

Managers and Supervisors. The managers/supervisors responsibilities are to:

- Classify each of their employees in relation to their potential occupational exposure
- Implement the exposure control plan in sections for which they are responsible (See additional section on training):
    - Assist in educating and training employees about the OSHA standard and the Exposure Control Plan
    - Maintain an up-to-date list of employees requiring training
    - Assure that annual training updates are completed
    - Review department policies and procedures that place the employees at risk for exposure and submitting revisions to the HR
    - Monitor employees for compliance in following the exposure control plan, documenting noncompliance, and counseling employees appropriately
    - Report exposures to the Director of HR to be recorded on worker compensation forms, referring employees for immediate exposure follow-up, and coordinating 6-month follow-up exams
    - Report device evaluation activities according to the evaluation criteria
    - Informing candidates during the interview and at hiring of the potential for exposure

Employees. The employee's responsibilities are to:

- Attend the bloodborne pathogen in-service and passing a test prior to assignment to tasks
- Know how to access the Exposure Control Plan
- Follow the Exposure Control Plan
- Report any exposures promptly to his or her supervisor

- Follow department directives if/when personal protective equipment needs cleaning or replacement

EXPOSURE DETERMINATION

OSHA requires employers to perform an exposure determination to identify employees that may incur occupational exposure to blood or other potentially infectious materials as a consequence of the performance of their job duties. The exposure determination is made without regard to the use of personal protective equipment. Each Supervisor will be responsible for classifying each of their employees in relation to their potential occupational exposure. The supervisor may consult with HR, the appropriate Division Director, or the Office of Surveillance and Epidemiology (OSE) as needed in order to determine such classification. All job positions will be classified as one of the following (Appendix B):

Class A. ALL employees have occupational exposure.

Class B. SOME employees have occupational exposure.

Class C. NO employees have occupational exposures.

This classification will be incorporated into each job description for which the employee is determined to be at risk of exposure. Supervisors will be responsible for notifying HR when changes in job duties result in a change in risk level, or when new positions are created that involve risk of exposure. Identification of the risk tasks associated with specific position titles can be found in Appendices B, C at the back of this document.

IMPLEMENTATION

Methods of Compliance

Effectively eliminating or minimizing exposure to bloodborne pathogens in this agency requires that several areas be addressed:

1. Using Universal Precautions
2. Emphasizing handwashing and handwashing facilities
3. Establishing engineering control including needle safety, sharps containers, use and evaluation of sharps with engineered sharps injury protections

4. Implementing appropriate work practice controls
5. Using necessary protective equipment
6. Implementing appropriate housekeeping procedures

Universal Precautions direct that body fluids/materials are treated as if infectious. The standard stresses Handwashing (Supplement 1) and requires employers to provide facilities and ensure that employees use them following exposure to blood. Engineering controls isolate or remove the bloodborne pathogens hazards from the workplace. Engineering controls include needle/sharps disposal containers, self-sheathing needles, safer medical devices such as sharps with engineered sharps injury protections and needleless systems. Work practice controls are those that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., the prohibition of recapping needles by a two-handed technique).

It sets forth procedures to minimize needle sticks, minimize splashing and spraying of blood, ensure appropriate packaging of specimens and regulated wastes, and decontaminate equipment or label it as contaminated before shipping to servicing facilities.

Employers must provide at no cost, and require employees to use appropriate personal protective equipment such as gloves, gowns, masks, mouthpieces and resuscitation bags which employers must clean, repair and replace when necessary.

The standard requires a written schedule for cleaning, identifying the method of decontamination to be used, in addition to cleaning following contact with blood or other potentially infectious materials. It specifies methods for disposing of contaminated sharps and sets forth standards for containers for these items and other regulated waste. Further, the standard includes provisions for handling contaminated laundry to minimize exposures.

1. Universal Precautions

All Class A and B employees (Appendix B) in the Kansas Department of Health and Environment (hereafter, "the department") will observe universal precautions to prevent contact with blood or other potentially infectious materials. Universal Precautions is a term that relates to adopting a specific perspective toward other peoples' blood or body fluids. These precautions are utilized to protect "at risk" employees from the unknown organisms

that may be present in the blood and body fluids of individuals to whom they are exposed. This perspective is directed by the following assumptions and behaviors:

- Assume that ALL blood is positive for HIV, HBV, and HCV
- Assume that ALL other human fluids/tissues are also positive
- When it is difficult to differentiate, treat ALL fluids as potentially infectious
- Assume that ALL individuals are carrying these disease organisms
- Avoid skin contact with blood and other potentially infectious materials
- Avoid eye, nose, and mouth contact with blood and other potentially infectious materials
- Avoid punctures/sticks with contaminated sharp objects

The following materials are considered to be potentially infectious materials:

- Blood and blood Products
- Body fluids:
    - Semen
    - Vaginal secretions
    - Pleural fluid
    - Pericardial fluid
    - Peritoneal fluid
    - Synovial Fluid
    - Amniotic Fluid
    - Saliva*
    - Breast milk**
- Any body fluid that contains blood (e.g., stool/emesis streaked with blood)
- Any unfixed organ or tissue (other than intact skin) from a human (living or dead).
- HIV containing cell or tissue cultures, organ cultures, and HIV, or HBV, or HCV containing culture medium or other solutions; and blood, organs, or other experimental animals infected with HIV, or HBV, or HCV.

* Saliva is considered infectious by OSHA only in dental settings; however, the department recognizes the risk of transmission of hepatitis B, herpes simplex, and other pathogens in saliva and considers saliva as potentially infectious.

** Breast milk does contain small amounts of HBV and HIV and has been documented to transmit disease. The department considers breast milk as potentially infectious even though the risk is small and OSHA does not recognize it as a potentially infectious fluid.

Universal precautions do not apply to feces, nasal secretions, sputum, sweat, tears, urine, and vomitus unless they contain visible blood. However, because of other harmful organisms that may be present, precautions should still be taken when dealing with these materials.

Universal precautions recommendations (based on Morbidity and Mortality Weekly Report1988; 37(24):377-88):

- All health care workers should routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient is anticipated. These barriers include gloves, masks, protective eyewear, gowns or aprons according to risk of exposure for the employee.
- If clothing is contaminated it is to be removed as soon as possible.
- Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.
- All health care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures.
- Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which there may be a need for resuscitation.
- Health care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.

- Pregnant health care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission. Pregnant laboratory employees are to report a possible or confirmed pregnancy to their supervisor according to the laboratory policies and procedures.

2. Hand washing

The objective of hand washing is to decrease the number of microorganisms on hands to prevent and/or reduce the spread of infection. There are two primary methods used to accomplish this objective: 1) kill microorganisms with antiseptic hand cleansing products and 2) physical removal of organisms from hands – use of soap and running water (this is what is meant by the terms washing hands, or handwashing).

Employees should be familiar with the location of the nearest handwashing facilities. Laboratory sinks, public restrooms, janitor closets, may be used for handwashing if they are normally supplied with soap. If the employee is working in an area without access to such facilities, an antiseptic cleanser may be used in conjunction with clean cloth/paper towels or antiseptic towelettes. If these alternative methods are used, hands should be washed with soap and running water as soon as possible.

In the absence of a true emergency, personnel should always wash hands:

- When arriving at the worksite
- Before
    - taking care of patients
    - invasive procedures
    - before all contact with immunosuppressed patients
    - eating
    - smoking

- After
    - direct care that involves skin contact with patients
    - removal of gloves
    - situations during which microbial contamination of hands is likely to occur (e.g., handling used alcohol wipes after injections)
    - leaving patient areas
    - after using the bathroom
    - touching inanimate objects that are likely to be contaminated (e.g., workbenches where specimens are placed)
- Anytime that hands or other skin surfaces are contaminated with blood, body fluids containing visible blood, or other body fluids to which universal precautions apply

When the employees of the department are assisting with patient care in the field at health departments, employees will seek out the health department's hand washing facilities before patient care occurs.

Hand washing Facilities

Because hand washing is so important, employees should be familiar with the location of the nearest hand washing facilities. Laboratory sinks, public restrooms, janitor closets, etc., may be used for hand washing if they are normally supplied with soap. When the employees of the department are assisting with patient care in the field or at health departments, employees will seek out the handwashing facilities before patient care occurs.

When department employees in roles as field representatives draw blood or have other patient contact, employees will use sinks in the patient's home if possible. If a sink, soap, and towel are not available then the use of a waterless antiseptic soap/hand gel cleanser substitute is acceptable. Employees then must wash their hands with soap and running water as soon as possible. OSHA requires a listing of locations for waterless soap substitutes, tasks requiring substitutes, and supervisors responsible for substitutes. The following table contains this information.

Table 1 – Hand washing substitute location, task, and responsible person

Location of Soap Substitute	**Task**	**Supervisor**
Field packet	Blood draws	STD program manager
Field packet	Blood draws	IMM program manager
Field packet	Blood draws	AIDS program manager
Field packet	TB skin test	TB program manager
Laboratory sink cupboard	Emergency handwashing	Chief of services

3. Engineering Controls

The objective of engineering controls is to isolate or remove the bloodborne pathogens hazards from the workplace. Engineering controls include needle/sharps disposal containers, self-sheathing needles, safer medical devices, such as sharps with engineered injury protections and needleless systems. Any engineering controls that perform the above function need to be checked and maintained in effective working condition.

Employees working in field offices or local health departments are responsible for knowing and following engineering controls in sites where they perform risk tasks. Needle boxes and

other controls used in local health departments will be maintained and supervised by the local health department.

Needle Safety & Sharps Containers

All health care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures, when cleaning used instruments, during disposal of used needles, and, when handling sharp instruments after procedures. Approved injury protection devices should always be utilized. Because moving one's hands toward a needle, blade or other sharp is a high risk behavior it is recommended that this behavior be avoided. Contaminated needles and other contaminated sharps will not be bent, recapped, removed, sheared, or purposely broken. If recapping is not avoidable the recapping or removal of the needle must be done by the use of a mechanical device or a one-handed technique.

Needles shall be disposed of in labeled sharps containers only.

- Sharps containers shall be closable, puncture-resistant, leak-proof on the sides and bottom, and must be labeled or color-coded.
- When sharps containers are being moved from the area of use, the containers should be closed immediately before removal or replacement to prevent spillage or protrusion of contents during handling or transport.

Use and Evaluation of Sharps with Engineered Sharps Injury Protections (SESIP)

With exception of the Kansas Department of Health and Environmental Laboratories and STD Disease Intervention Specialists, employees must use the technologies available in the work setting. The Laboratories provides needles and syringes for use in the laboratory in transfer of isolates from medium to medium or to slides, etc. Needleless systems are not appropriate for these laboratory procedures. Whenever needleless systems or sharps with engineered sharps injury protections are available for procedures, employees should use the safer technologies. According to the 2001 revisions (Appendix A) review of SESIP

technologies will be reported in the annual plan and are the product of input and participation by non-supervisory staff members.

Review of these devices (Appendix D 1 & 2) will include at minimum the:

- brand name of the device,
- evaluation method,
- persons involved in the evaluation, and,
- assessment and justification for the decision to accept or reject the product.

Additional information may be requested to clarify the impact of potential change and decision-making.

Appendix D contains the review criteria and example report.

4. Work Practice Controls

Restrictions

In work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials, employees should never:

- Eat
- Drink
- Smoke
- Apply cosmetics or lip balm
- Handle contact lenses
- Keep food or drink in refrigerators, freezers, shelves, cabinets, or on counter tops where blood or potentially infectious materials are present

Mouth pipetting and suctioning of blood or other potentially infectious materials is **prohibited.**

All procedures will be conducted in a manner that minimizes splashing, spraying, splattering, and generating of droplets of blood or other potentially infectious materials. Methods employed in the laboratory are available in the Laboratory Safety Manual.

Specimen Acquisition and Handling

Specimens of blood or other potentially infectious materials will be placed in a container that prevents leakage during collection, handling, processing, storage, and transport. Gloves will be used to handle specimens for transport or receiving. The containers used for this purpose will be labeled or color-coded. For staff that will draw blood or obtain other specimens in the field, specimens will be placed in combination packaging that has been labeled with biohazard sign, is durable, and is leak-proof or the shipping system, provided by Kansas Department of Health and Environment Laboratories (KDHEL) that meets the requirements of the clinical samples being collected.

Inside the laboratory, all specimens will be handled using universal precautions. All specimens that are shipped out of the laboratory will be triple packaged, including a secondary container that is leak-proof. All packaging and shipping requirements as defined by 49 CFR Parts 171-178 and 39 CFR Part 111 will be implemented

For additional information refer to laboratory's guidance regarding packaging and shipping of specimens http://www.kdheks.gov/labs/packaging_and_shipping.html and refer to the Laboratory Safety Manual.

Contaminated Equipment

Equipment that has become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary unless the decontamination of the equipment is not feasible.

There is no equipment used by the department that cannot be decontaminated and/or repaired by department personnel.

5. Personal Protective Equipment (PPE)

Rules to follow:

- Always wear personal protective equipment in exposure situations.
- Remove PPE that is torn or punctured, or has lost its ability to function as a barrier to blood-borne pathogens.

- Replace PPE that is torn or punctured.
- Remove PPE before leaving the work area.

If an employee works in an area with routine exposure to blood or potentially infectious materials, the necessary PPE should be readily accessible. Contaminated gloves, clothing, PPE, or other materials should be placed in appropriately labeled bags or containers until it is disposed of, decontaminated, or laundered. It is important that the employee locates these bags or containers before beginning work.

Gloves

CDC has recommended that health care workers wear gloves to:

- reduce the risk of personnel acquiring infections from patients,
- prevent health-care worker flora from being transmitted to patients, and,
- reduce transient contamination of the hands of personnel by flora that can be transmitted from one person to another.

Gloves should be made of latex, nitrile, rubber, or other water impervious materials. If glove material is thin or flimsy, double gloving can provide an additional layer of protection. Also, if employee has cuts or sores on his or her hands, these should be covered with a bandage or similar protection as an additional precaution before donning gloves. Employee should always inspect gloves for tears or punctures before putting them on. If a glove is damaged, it should never be used. When taking contaminated gloves off, employee should assure that the outside is not touched by any bare skin and dispose of them in a proper container so that no one else will come in contact with them.

The following general guidelines are recommended regarding use of gloves.

1. Use sterile gloves for procedures involving contact with normally sterile areas of the body.
2. Use examination gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other patient care or diagnostic procedures that do not require the use of sterile gloves.
3. Change gloves between patient contacts.

4. Do not wash or disinfect surgical or examination gloves for reuse. Washing with surfactants may cause "wicking," i.e., the enhanced penetration of liquids through undetected holes in the glove. Disinfecting agents may cause deterioration.
5. Use general-purpose utility gloves (i.e., rubber household gloves) for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures. Utility gloves may be decontaminated and reused but should be discarded if they are peeling, cracked, or discolored, or if they have punctures, tears, or other evidence of deterioration.

Refer to Appendix E1 for tasks that require glove use.

If an employee requires a smaller or larger size glove or develops an allergy to the current gloves provided to employees, the department will provide an appropriately sized glove, or powder-less gloves or glove liners for employees with allergies. It is the responsibility of the employee to report glove problems to their immediate supervisor for appropriate equipment and work assignment.

The Division of Health provides disposable gloves to staff that practice in the field. Gloves are stored by individual bureau. When public health nurses/employees or field staff practice in local health departments, they must locate the glove boxes before providing patient care.

Body protection – Gowns, clothing covers

Public health nurses/employees may need a lab coat, gown or apron, in a health department or clinic situation. It is expected that these items will be provided by the facility. The individual should reimburse the local health department or clinic for items, obtain a receipt, and then include PPE expenditures on travel voucher. Reimbursement will be issued to the employee with travel expenses.

- Gowns, aprons, lab coats may be worn to protect clothing and to keep blood or other contaminated fluids from soaking through to the skin.

Normal clothing that becomes contaminated with blood should be removed as soon as possible because fluids can seep through the cloth and come in contact with skin.

Contaminated laundry should be handled as little as possible, and it should be placed in an appropriately labeled bag or container until it is decontaminated, disposed of, or laundered.

Employees should use universal precautions and treat all blood or other potentially infectious materials as if they are contaminated. Contact should be avoided whenever possible, and whenever it is not possible, appropriate personal protective equipment should be worn. If the employee is in a situation where there has been contact with blood or other potentially infectious materials and there is no standard PPE available, the employee should do whatever is possible to provide protection. For example, a towel, plastic bag, or some other barrier could be used to help avoid direct contact.

Eye/ face protection

Any time there is a risk of splashing or vaporization of contaminated fluids, goggles and/or other eye protection should be used to for eye protection. Bloodborne pathogens can be transmitted through the thin membranes of the eyes, so it is important to protect them. Splashing could occur while cleaning up a spill, during laboratory procedures, or while providing first aid, or medical assistance.

Face shields may be worn in addition to goggles to provide additional face protection. A face shield will provide additional protection against splashes to the nose and mouth.

6. Housekeeping

Routine Cleaning – The department will maintain a clean, safe, and sanitary worksite. When the department does not contract for housekeeping services, supervisors will be responsible for determining and implementing an appropriate written schedule for cleaning and method of decontamination based upon the facility purpose, type of surface cleaned, soil present, and tasks or procedures being performed in the area.

Cleaning Areas where Blood and Other Potentially Infectious Materials is Present – The department laboratories are the only area where blood and other potentially infectious materials are present. The laboratory has established cleaning schedules and list of disinfectants utilized in the laboratory. Details of laboratory procedures can be found in the Laboratory Safety Manual.

The method to clean up blood and/or spills of other potentially infectious materials is as follows:

1. Don gloves and spray spill with disinfectant
2. Remove visible material with disposable towels or other appropriate absorbent materials, place in plastic bag, and secure bag.
3. Disinfect area with bleach solution or EPA-registered disinfectant that kills HBV, HCV, and HIV.
4. Remove gloves and wash hands.
    - If spill is large, other protective equipment may be necessary (i.e., waterproof gown, protective eyewear, booties). If bagged waste drips, double bag and label with biohazard sign and dispose of accordingly.

Management of Broken Glassware

Broken glassware that may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means such as a brush, tongs or forceps, and a dustpan. Broken glass will be placed in a sharps container. Tools used for clean-up will be disinfected with a bleach solution diluted 1:10 with water or an EPA-registered disinfectant that kills HBV, HCV, and HIV.

Regulated Waste

Regulated medical waste in Kansas is governed by K.A.R. 28-29-27 (Appendix A). Medical services waste refers to solid waste materials that are potentially capable of causing disease or injury and that are generated in connection with human or animal care through inpatient and outpatient services. Medical waste is found at the state laboratory. Refer to the Laboratory Safety Manual for procedures related to laboratory activities.

Regulated waste includes:

- Any liquid or semi-liquid blood or other potentially infectious materials Contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed
- Items that are caked with dried blood or other potentially infectious materials and are capable of releasing these material during handling
- Contaminated sharps

- Pathological and microbiological wastes containing blood or other potentially infectious materials

All regulated waste must be labeled and disposed of properly. Follow procedures in the area or facility where you are performing risk tasks. These must be disposed of at an approved facility. Most departments or facilities that generate regulated waste will have a contract with an outside disposal company to pick up the waste and take it to an approved incineration/disposal facility.

Laundry

Laundry contaminated with blood or other potentially infectious materials will be handled as little as possible. The only clothing needing laundering is located at the state laboratory. Refer to the Laboratory Safety Manual for procedures.

HAZARD COMMUNICATIONS

Signs

A biohazard sign is required to be posted on HIV, HBV, HCV research laboratories. Because the department's laboratory is not a research facility, no biohazard sign is necessary at the entrance to the lab.

Labeling

The items that require a biohazard label are:

- Containers of regulated infectious waste
- Refrigerators and freezers containing blood or other potentially infectious materials
- Containers used to store, transport, or ship blood or other potentially infectious materials

Warning labels are to be affixed to containers of regulated waste, including

- Refrigerators and freezers containing blood or other potentially infectious materials
- Containers used to store, transport, or ship blood or other potentially infectious materials
- Contaminated equipment being sent for repair of maintenance (an extra label must state which portion of the equipment remains contaminated)

Items that do not require the biohazard label include:

- Red bags or containers
- Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use
- Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal
- Regulated waste that has been contaminated

Labels and bags used to dispose of regulated waste must have the biohazard symbol readily visible on them. Regulated waste should be double-bagged to guard against the possibility of leakage if the first bag is punctured.

Labels should display this universal biohazard symbol.

This symbol should be black on red.

Employee Education

The department HR will coordinate with supervisors to ensure that all Class A and B employees with potential occupational exposure participate in a training program that must be provided at no cost to the employee and provided during working hours. Copies of the written plan will be available to employees on the department intranet site.

Training schedule and Responsibilities for all Class A and B employees:

- Initially upon hiring
- Yearly, subsequent to training upon initial hiring
- New Class A and B employees will receive training before initial assignment to tasks where occupational exposure may occur
- Employees with occupational exposure will be provided additional training if a new task or procedure affects the employee's occupational exposure
- Training will be ensured by the Supervisor of the employee
- Supervisor may consult with HR or the Office of Surveillance and Epidemiology (OSE) for purposes of assuring appropriate content of the training

- HR will assure that supervisors are provided training in all aspects of implementation of the Exposure Control Plan, including specific training for the employees at risk. A variety of methods and media may be used to train employees

Training Content – Training for employees will include an explanation of the following:

- Overview of the OSHA standard for bloodborne pathogens and the location of the standard for review as needed
- Modes of transmission of bloodborne pathogens
- The department exposure control plan and the means by which employees can obtain a copy of the plan
- Procedures that may involve exposure to blood and other potentially infectious materials
- Control measures to prevent exposure to blood and other potentially infectious materials including engineering controls, work practices, and PPE
- Information on the types, selection, proper use, location, removal, handling, decontamination and disposal of PPE
- Pre-exposure hepatitis B vaccination program including information of vaccine efficacy, safety, method of administration, and benefits of being vaccinated
- Post exposure reporting, medical evaluation, and follow-up
- Hazardous labels and signs used by KDHE

Employees will have an opportunity to ask questions as a part of the training session. The person conducting the training will be knowledgeable in the subject matter identified by the elements of the workplace training program.

Employees who are only proficient in a foreign language or have a disability will have information conveyed by an interpreter or by an appropriate method of education for their disability.

The training instructors and supervisors of employees affected by the plan will provide the OSHA-required training with work unit-specific policies to employees. These training programs will be given to all new employees before an employee is assigned to tasks where

occupational exposure may occur. All employees in Class A or B positions with occupational exposure will receive training on bloodborne pathogens, including but not limited to the human immunodeficiency virus (HIV), and the hepatitis B virus (HBV), and the hepatitis C virus (HCV).

Training records will be maintained for three years from the date on which the training occurred. Records will include the following:

1. Date of training session,
2. Summary of training session,
3. Names and qualification of persons conducting the training, and
4. Names and job titles of all persons attending the training session.

The forms in Appendix F (or equivalent forms specific to the organizational work unit) may be used to document group training sessions. Individuals providing group training under the aegis of this plan should:

1. document the participation of each employee (including supervisors of employees, and
2. provide written communication to the employee's supervisor, the employee, and to HR.

When supervisors of employees with potential risk provide annual training to those employees on an individual basis, training will be documented in writing to HR and the employee.

VACCINATION AND EXPOSURE FOLLOW UP CARE

Vaccination

All Class A and B employees (Appendix B) in the department will be offered the hepatitis B vaccine at no cost to the employee. The employee will be offered the vaccine after training and within 10 working days of their initial work assignment that involves the potential for occupational exposure to blood or other potentially infectious materials. The employee may decline the vaccination for various reasons i.e. previously vaccinated, medical contraindications, documentation of immune status, or by personal choice.

The employee will sign the appropriate declination statement (Appendix G (1) and Appendix G (3)). If the employee later chooses to have the vaccination it will be provided within 10 days at no cost to the employee.

The supervisor will arrange hepatitis vaccination times with the department's identified agency, refer them to that agency for injections, or obtain the waiver. It will be the responsibility of the supervisor to offer the vaccine to new employees and to arrange for the employee to receive it.

The procedure for obtaining the vaccine for the employee is as follows:

1. **Contact the Immunizations Program of the local health department at the employee's work location** and schedule an appointment for the employee.
2. Prepare a purchase order with local health department as vendor and department (with your Bureau/Section/Program) as purchasing agent.
3. Prepare a brief memo on department letterhead addressed to the local health department Immunizations Program to be taken by the employee with the purchase order to the local health department at time of the appointment. The memo should address following issues:
    - Identify the employee as a KDHE employee,
    - Clarify that the purpose of the visit is for the employee to receive a hepatitis B vaccine dose,
    - Clarify that KDHE will reimburse the local health department for all costs of the service as per the accompanying purchase order, and
    - Request that the local health department provide KDHE with documentation that the dose was administered for the employee's KDHE medical record.

NOTE: Repeat the process for each dose of vaccine.

Post Exposure Evaluation and Follow-up

An exposure is defined as: a specific eye, mouth, other mucous membrane, parenteral, or non-intact skin contact (including intact skin when exposure is prolonged, involves

extensive surface area of the skin, involves large quantities of the potentially infectious material, or involves material known to be infected with high titers of virus) with blood or other potentially infectious materials resulting from the performance of an employee's duties. The steps in an exposure evaluation and follow-up are described as follows.

Documentation of exposure

When an employee incurs a possible exposure, the employee will report the incident to his/her immediate supervisor at once. The supervisor will decide whether a true blood or body fluid exposure has occurred. Refer to Appendix H for risk assessment factors. If there is a question of true exposure, the supervisor may consult the Office of Surveillance and Epidemiology (785-296-2951 daytime; Epidemiology Hotline 1-877-427-7317 nights and weekends). If a true exposure has occurred, the supervisor will arrange for the employee to receive medical evaluation without delay, preferably within one hour (See Appendix I (1) & I (2) - Post exposure Prophylaxis Recommendations). After arranging for medical attention for the employee, the supervisor will contact HR to report the incident. This report will include description of where, when, and how the incident occurred; what potentially infectious materials were involved; source of the potentially infectious materials; circumstances surrounding the incident; and personal protective equipment used at the time; and, action taken as a result of the incident. The supervisor will also complete an Employer's Report of Accident form 1101-A (see Appendix J) and submit it to HR as soon as possible to comply with Worker's Compensation injury reporting requirements. If the exposure is due to a sharps injury, the supervisor will assure that the 1101-A form includes the following information:

- Setting
- Program
- Job working title of injured employee
- Procedure
- Type of device (vacutainer, etc.)
- Brand name of device
- Description of incident

Forward the completed form to HR where the information regarding sharps-related injuries are maintained in a separate file – the "Sharps Injury Log." This latter procedure is not required for sharps injuries in which the sharp is not contaminated and for which the incident does not meet the definition of an exposure.

Referral and Care of Employee

Follow up will be provided by the appropriate contract health care provider (see Appendix K for list of contract health care providers by region). If the distance to one of these providers is excessive, the employee should present to the nearest hospital emergency room. Use of private physicians for this purpose may be problematic because private physicians may not have reimbursement agreements in place with the Worker's Compensation Program. Hospitals are more likely to have such agreements in place and they are more likely to be experienced in providing post-exposure evaluation and treatment.

When the supervisor arranges for the employee to receive evaluation and treatment, in order to facilitate the process, the health care provider should be advised that the:

(1) patient is a State of Kansas Employee,

(2) medical care to be provided is for an occupational injury that is covered by the State Worker's Compensation Program,

(3) injury is a potential bloodborne pathogen exposure that should be evaluated and treated just as the hospital would evaluate and treat one of its own employees who had incurred such an occupational injury, and

(4) where to access a copy of the Kansas requirements for compliance with OSHA bloodborne pathogens standard and appendices.

When an exposure occurs, the supervisor will also provide the health care provider with information relevant to the incident including: circumstances and route of exposure, the employee's hepatitis B vaccination status, and other relevant medical information. If possible, the supervisor will obtain and supply the health care provider with the identity, risk levels, and sero-status of the source person for HBV, HCV, and HIV (refer to Appendix H). If the source person's blood is at the state laboratory, it will be tested for HIV, HCV, and HBV only after obtaining consent for testing and release of information since there is no

provision in Kansas law for testing a patient or release of testing results without consent. It will be the responsibility of the supervisor to notify the source individual, obtain written permission, obtain additional blood if necessary, and return signed consent forms and blood to the Virology/Serology Lab. The supervisor may request assistance with these tasks from the health care provider or the local health department. However, it is ultimately the responsibility of the supervisor to carrying out these measures.

If a public health nurse or field staff experiences an exposure in the field, the source patient's blood will be drawn for HIV, HCV, and HBV by appropriate local health department staff, after obtaining consent from the source patient. Blood will then be sent to the state laboratory for testing at no cost to the employee. The health care provider will arrange for testing of the employee for HBV, HCV, HIV, and other tests as deemed necessary at no cost to the employee. If the employee does not wish immediate testing, the employee will be offered the option of donating a blood specimen for later testing. The blood sample will be preserved for at least 90 days to allow the employee to decide if the blood should be tested. If the employ refuses to provide blood or allow testing, this will be documented in their medical file.

The health care provider will provide post-exposure prophylaxis in accordance with CDC recommendations as summarized in Appendix I, and will notify the employee of all test results. The exposed employee will be instructed to maintain the confidentiality of the source patient's name and sero-status according to Kansas law. The health care provider will also evaluate any reported illness that may stem from the exposure incident.

The department's HR will obtain and provide the employee with a copy of the health care provider's written opinion within 15 days of the completion of the evaluation. This opinion will be limited to the following information:

- documentation that the employee has been informed of the results of the evaluation
- whether hepatitis B vaccine is indicated and if vaccination was given

- any medical conditions resulting from exposure to blood or other potentially infectious materials that require further evaluation or treatment

All other findings or diagnoses shall remain confidential and shall not be included in the report.

Medical Records

Maintenance

The health care provider will maintain confidential, secured employee medical files for the duration of employment plus 30 years. HR will inform the health care provider when an employee resigns or retires.

- A separate locked file will be maintained by HR for department employees who have an occupational exposure.
- Files will be confidential and will not be disclosed to any person without the employee's written consent except as required by Kansas law.
- Records will be maintained for duration of employment plus 30 years.

The department's HR will establish and maintain an accurate record for each employee with an occupational exposure in accordance with the OSHA standard. This record will include:

- name and social security number of employee
- copy of employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and medical records relevant to the employee's ability to receive vaccination
- copy of all results of examinations, medical testing, and follow-up procedures
- copy of the health care provider's written opinion about the exposure
- copy of the information provided to the health care provider when the employee was sent for exposure assessment and care

Apart from the circumstances surrounding the exposure itself, all other findings or diagnosis by the health care professional(s) will remain entirely confidential.

Record Keeping

The following records will be maintained by the department:

- training records
- hepatitis B vaccination records
- incidents of noncompliance with exposure control plan
- exposure incidents and medical follow up
- completed Post-Exposure Report Forms (including a sharps-related injury log)

Location and duration of record keeping:

- employee education training records will be maintained for 3 years from the time of training
- hepatitis B vaccination records will be kept in HR in a locked file for duration of employment plus 30 years
- Counseling in regard to non-compliance will be documented according the Kansas Personnel Policies regarding positive discipline utilizing an oral reminder, written reminders, then decision-making-leave with continued non-compliance. Supervisor Training Manual, Section Problems, pages 7 and 8 explains how to counsel employees. Civil Service Guidance and Discipline is found in the following regulations: Kansas Regulation 1-10-6; Kansas Regulation 1-10-7; Kansas Regulation 1-10-8.
- all exposure incidents, follow up consultation, and recommendations will be maintained by HR for duration of employment plus 30 years
- Post Exposure Report Forms will be retained by HR, including a Sharps Injury Log, for duration of employment plus 30 years

Appendix A

Rules, Regulations, Statutes

The Occupational Safety and Health Administration's (OSHA) Rule 29 CFR 1910.1030 (http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051) on bloodborne pathogens became effective March 6, 1992 and revisions were published January 18, 2001 to the "Federal Registers Occupational Exposure to Bloodborne Pathogens; Needlestick and Other Sharps Injuries; Final Rule. - 66:5317-5325 http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=FEDERAL_REGISTER&p_id=16265&p_text_version=FALSE).

The purpose of the standard is to protect employees by limiting occupational exposure to blood and other potentially infectious materials (OPIM) since exposures could result in transmission of blood borne pathogens that could lead to disease or death.

Private health-related employers are required to implement the standard and will be cited by OSHA if they are not in compliance. In accordance with K.S.A. 44-636 (http://www.kslegislature.org/legsrv-statutes/getStatuteInfo.do;jsessionid=04FFD0D60236F2246A440F06C76D7327) as administered by the Industrial Safety and Health Section of the Kansas Department of Human Resources, public sector employers must also be in compliance with the OSHA rule concerning blood-borne pathogens.

In accordance with the OSHA Blood Borne Pathogens Standard referenced above, the exposure control plan has been developed for employees of the Kansas Department of Health and Environment (KDHE).

Other Resources:

Workbook for Designing, Implementing, and Evaluating a Sharps Injury Prevention Program

http://www.cdc.gov/sharpssafety/

Safety and Health Topics
Bloodborne Pathogens and Needlestick Prevention

http://www.osha.gov/SLTC/bloodbornepathogens/index.html/

USDOT Regulations
http://hazmat.dot.gov/regs/rules.htm
http://hazmat.dot.gov/

USPS / Domestic Mail Manual
http://www.usps.com/postagesolutions/_pdf/fr29se00.pdf
http://pe.usps.com/cpim/ftp/manuals/dmm300/601.pdf

Appendix B

KDHE Bloodborne Pathogen Plan
List of Positions at Risk of Exposure

Updated: **25-Jul-05**

Org Unit	Pos No.	Job Class	Risk Class
Division of Labs			
Neonatal Chemistry	K0043460	Microbiologist II	B
	K0046750	Lab Tech III	B
	K0052929	Lab Tech III	B
	K0057228	Microbiologist III	B
	K0067598	Chemist II	B
	K0075787	Sr Lab Scientist	B
Laboratory Improvement	K0052163	Lab Improvement Spec	B
	K0066145	Lab Improvement Spec	B
	K0067624	Lab Improvement Spec	B
	K0073338	Lab Improvement Spec	B
	K0108399	Public Svc Exec II	B
	K0176330	Lab Improvement Spec	B
	K0176332	Lab Improvement Spec	B
	K0176362	Lab Improvement Spec	B
Customer Service	K0041205	Sr Admin Asst	B
	K0060938	Sr Admin Asst	B
	K0064662	Lab Tech II	B
	K0070294	Sr Admin Asst	B
	K0072417	Public Svc Admin II	B
	K0077304	Lab Tech II	B
	K0178880	Lab Tech II	B
	K0178882	Lab Tech II	B
	K0213378	Lab Tech II	B
Microbiology	K0043472	Microbiologist II	B
	K0044110	Microbiologist II	B
	K0045696	Lab Tech II	B
	K0050693	Microbiologist II	B
	K0051318	Microbiologist III	B
	K0055915	Microbiologist II	B
	K0057008	Microbiologist II	B
	K0057303	Microbiologist II	B
	K0063778	Lab Tech I	B
	K0064939	Lab Tech II	B
	K0066437	Public Svc Exec III	B
	K0070173	Lab Tech II	B
	K0075967	Public Svc Exec II	B
	K0215199	Microbiologist III	B
Virology/Serology	K0041873	Microbiologist II	B
	K0046356	Public Svc Exec II	B
	K0052256	Microbiologist II	B
	K0053670	Lab Tech III	B

	K0054250	Microbiologist II	B
	K0061519	Public Svc Exec III	B
	K0067815	Microbiologist III	B
	K0076235	Microbiologist I	B
	K0212256	Microbiologist	B
Environmental Chemistry	K0072967	Chemist II	B
	K0076713	Chemist III	B
	K0102757	Chemist II	B
		Chemist III	B
		Public Svc Exec II	B
		Public Svc Exec II	B
Division of Health			
Bureau of Disease Control and Prevention	K0047624	Disease Intervention Spec	A
	K0049976	Disease Intervention Spec	A
	K0051123	Disease Intervention Spec	A
	K0115017	Hlth/Env Program Analyst	B
	K0115018	Disease Intervention Spec	A
	K0124678	Health Officer	B
Office of Local and Rural Health	K0049202	Public Health Nurse III	B
	K0050952	Public Health Nurse III	B
	K0053376	Public Health Nurse III	B
	K0066501	Public Health Nurse III	B
	K0069389	Public Health Nurse III	B
	K0073126	Public Health Nurse III	B
Bureau for Children, Youth and Families	K0057982	Nutritionist Senior	B
	K0061232	Public Health Nurse III	B
	K0069857	Nutritionist	B
	K0138343	Nutritionist	B
	K0146670	Public Health Nurse III	B
Division of Environment			
Bureau of Air and Radiation	K0050062	Env Scientist IV	B
	K0055825	Rad Control Inspector	B
	K0063306	Prog Consultant II	B
	K0064805	Rad Control Inspector	B
	K0070005	Rad Control Inspector	B
	K0077758	Rad Control Inspector	B
	K0077759	Rad Control Inspector	B
	K0109889	Rad Control Inspector	B
	K0111226	Env Scientist IV	B
Bureau of Env Field Svcs	K0046026	Rad Protection Spec	B

Appendix C

KDHE Risk Determination Document

Explanation of risk duties/tasks

Position	Task
Laboratory	
Sr. Lab Scientist, PSE III	Processing specimens
Chemist I, II, and III	Processing specimens
Lab Tech. I, II, and III	Processing specimens
Microbiologist I, II, III	Processing specimens
Laboratory Improvement Spec.	Potential contact with blood
Adm Asst., Sr. Adm. Asst	Unpacking specimens
Office of Health Promotion	
Epidemiologist, HEPA	Drawing blood
DIS, Health Officer, Med Invest	Drawing blood
Office of Local and Rural Health	
PHN III	Drawing blood Injections Physical exams
Bureau for Children, Youth and Families	
Nutritionist	Finger/heel sticks
Senior Nutritionist	Finger/heel sticks
PHN III	Drawing blood Injections Physical exams
Bureau of Air and Radiation	
Env. Scientist IV	Inspection of contaminated medical equipment
Radiation Control Inspt.	Inspection of contaminated medical equipment
Radiation Protection Spec.	Inspection of contaminated medical equipment
Program Consultant II	Inspection of contaminated medical equipment
Bureau of Disease Control and Prevention	
PHN III	Assessment of active TB disease patients
Disease Intervention Spec	Venipuncture (drawing blood)

Appendix D (1)

Evaluation of *Sharps with Engineered Sharps Injury Protections* (SESIP)

Report Year _____

The following information will be reported annually as part of the review and/or update of the Bloodborne Pathogens Exposure Control Plan. Please provide this information to the Exposure Control Plan Committee chairperson:

- Identify the devices considered for evaluation and identify those actually evaluated (brand name included).
- Has the device being considered for replacement been associated with an injury?
- State what is different between the old and new device.
- Who of the staff did the evaluation(s), the job titles and number of persons in that job.
- How the evaluation was performed, explain the basic plan/implementation of the evaluation.
- State the per unit cost of the old and new device
- State the positive and negative comments about the new device.
- State whether the evaluated device was selected for use or not and why (why not)

Appendix D (2)

Evaluation of *Sharps with Engineered Sharps Injury Protections* (SESIP)

Report Year __2003__

The following information will be reported annually as part of the review and/or update of the Exposure Control Plan. Please provide this information to the ECP _____

- Identify the devices considered for evaluation and identify those actually evaluated (brand name included).

Abbott syringe with self-sheathing needle

- Has the device being considered for replacement been associated with an injury?
    - *NO, this product is a new design*
- State what is different between the old and new device.
    - *The needle on the previous syringe has to be covered by physically placing the protective device over the needle, The new one is activated without having to put hand/fingers near the needle tip*
- Who of the staff did the evaluation(s), the job titles and number of persons in that job.
    - 3 *DI who draw blood in a clinic setting and* 1 *who primarily does this work in the field*
- How the evaluation was performed, explain the basic plan/implementation of the evaluation.
    - *The employees were supplied 25 syringes to use for a week and then provide feedback about strengths and weaknesses of the device*
- State the per unit cost of the old and new device
    - *Essentially the same price*
- State the positive and negative comments about the new device.
    - *Positive comments are that the device does not require much change in technique or disposal*
    - *Negative comments: "takes some getting used to" , "have to remember to activate the sheath"*
- State whether the evaluated device was selected for use or not and why (why not)
    - *Was decided to change to the new syringe because most of the evaluators felt positively about it and that changing would not incur a substantial change is cost of this product.*

Appendix E (1)

Personal Protective Equipment by Task

The following tables list the employee responsibilities for Hand washing and personal protective equipment (PPE) by task.

Laboratory - Listed below are the minimum requirements for controlled situations to protect the health care worker from potentially infectious agents. This list is not all inclusive, so judgment is required on the part of the health care worker to assess the need for additional barrier protection in less controlled situations. If an employee has an area of broken skin on their hands, they are responsible for protecting it through the use of gloves. Sterile technique is to be used during sterile procedures.

	Hand-washing	Gloves	Lab Coat/ Plastic Apron	Mask	Eye Protection
Handling and Processing opened specimens	X	X	X		X
Opening Specimens (without hood or other device)	X	X	X		X
Opening specimens (with hood or other device)	X	X	X		
Cleaning work surface or spills	X	X	X		X
Processing filter paper blood spots	X	X	X		X
Processing filter paper blood spots out of a hood	X	X	X	X	X
Processing lead specimens	X	X	X		X
Contact with leaking package	X	X	X		X

1. For routine procedures, such as histological and pathologic studies or microbiologic culturing, a biological safety cabinet is not necessary. However, biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for generating droplets. These include activities such as blending, sonicating, and vigorous mixing

2. Mechanical pipetting devices should be used for manipulating all liquids in the laboratory. Mouth pipetting is prohibited.

3. Laboratory work surfaces should be decontaminated with an appropriate disinfectant after a spill of blood or other body fluids and when work activities are completed.

4. Contaminated materials and equipment used in laboratory tests should be decontaminated before processing or be placed in bags and disposed of in accordance with institutional policies for disposal of infectious waste.

5. Scientific equipment that has been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired in the laboratory or transported elsewhere.

6. All persons should wash their hands after completing laboratory activities and should remove protective clothing before leaving the laboratory.

7. Gloves should be removed when leaving work areas.

8. Computer terminals with plastic overlays can be used with gloves, but must be wiped down with a 10% bleach solution once during the shift, at the end of the shift, and as needed.

9. If telephones are answered with gloves on, protect receiver with a paper towel.

PERSONAL PROTECTIVE EQUIPMENT BY PATIENT CARE ACTIVITIES

Patient care activities - Listed below are the minimum requirements for controlled situations to protect the health care worker from potentially infectious agents. This list is not all inclusive, so judgment is required on the part of the health care worker to assess the need for additional barrier protection in less controlled situations. If an employee has an area of broken skin on his hands, the employee is responsible for protecting it through the use of gloves. Sterile technique is to be used during sterile procedures.

	Hand-washing	Gloves	Lab Coat/ Plastic Apron	Mask	Eye Protection
Clean-up of an incontinent patient	X	X	S		
Cleaning surfaces of blood or other body fluids	X	X			
Collecting stool, urine, sputum, or wound specimens	X	X			

Direct contact with patient with forceful or productive cough	X			X	P
CPR with device	X	X			
Drawing field bloods	X	X			
Finger or heel sticks	X	X			
Medication administration: Orally	X				
Medication administration: IV piggyback	X				
Medication administration: IV starts	X	X			
Medication administration: IV, direct into hub of catheter	X	X			
Physical assessment	X				
Vital signs (not including rectal temperature)	X				
Vital signs (including rectal temperature)	X	S			
Dressing change: burns	X	X	S		
Dressing change: large amount of drainage	X	X	S		
Dressing change: routine	X	X			

Legend: **X** = Routinely **S** = If soiling is likely **P** = If splattering is likely

Appendix E (2)

Personal Protective Equipment by Radiation Control field inspections tasks

Radiation control field inspections tasks and PPE for radiation control - Listed below are the minimum requirements recommended during controlled situations, to protect radiation control staff from potentially infectious agents. This list is not all inclusive, so judgment is required on the part of staff to assess the need for additional barrier protection in less controlled situations. If an employee has an area of broken skin on their hands, they are responsible for protecting it through the use of gloves.

	Hand-washing	Gloves	Gowns
Swipe sample collection	X	X	
Survey or search of used needles	X	X	
Monitoring radiation in x-ray suite where blood or body fluids are present and operator treats as controlled area	X	X	
Responding to an incident where radiation materials and blood or OPIM have mixed together	X	X	S

Legend: **X** = Routinely **S** = If soiling is likely

1. For routine procedures, such as x-ray machine surveys using test stands or monitoring radiation levels in nuclear medicine suites, care should be taken to insure that the equipment is not placed in or on surfaces that are wet. If surveys must be done on such surfaces and the operation is one that can produce potentially infectious agents, then the equipment should be bagged or covered as much as possible and the barrier materials disposed at the site in the correct manner.
2. Liquid samples should not be collected using mouth pipetting.
3. Contaminated equipment and samples or sample containers will be decontaminated before processing or be placed in bags and disposed in accordance with institutional policies for the disposal of such wastes.
4. Scientific equipment (survey meters, test stands, etc) that have been contaminated with blood or other body fluids should be decontaminated and cleaned before being repaired or transported to the manufacturer.
5. All surveyors should wash their hands after completing a survey in a medical laboratory or dental facility.
6. If protective clothing or shoe covers are required, these shall be removed and collected in bags for disposal in the same manner as those potentially contaminated with radioactive materials.
7. Gloves shall be removed when leaving work areas, using the techniques for removing gloves contaminated with radioactive materials.

Appendix F (1)

Training record/forms

Kansas Department of Health and Environment

Employee Training for Blood Borne Pathogens

Date _____

Bureau _____

Instructor(s) _____

_____

Objective:

Participants will be able to discuss and follow the requirements for the Kansas Department of Health and Environment exposure control plan based on the OSHA Blood Borne Pathogens Final Rule, 29 CFR Part 1910.1030.

The areas covered are:

A. Overview of OSHA standard for blood borne pathogens and location of the standard and exposure control plan.

B. Modes of transmission of blood borne pathogens.

C. KDHE exposure control plan and the means by which employees can obtain a copy of the plan.

D. Procedures which may involve exposure to blood and OPIM.

E Control measures to prevent exposure to blood and OPIM including engineering controls, work practices, and PPE.

F. Information on the types, selection, proper use, location, removal, handling, decontamination and disposal of PPE.

G. Preexposure hepatitis B vaccination including information on vaccine efficacy, safety, method of administration, and benefits of being vaccinated.

H. Postexposure reporting, medical evaluation, and follow-up.

I. Hazardous labels and signs used by KDHE.

Appendix F (2)

Training record/forms

Participant Sign-in Sheet

Name	**Job Title**	**Bureau**	**KIPPS Number**

Appendix G (1)

Vaccination Declination Form

Date: _____

Employee Name: _____

Employee ID#: _____

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B viral (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself.

However, I decline the hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the hepatitis B vaccine, I can receive the vaccination series, at no charge to me, at that time.

Employee's name _____

Employee's signature _____

Work Unit (Bureau/Office) _____

Date _____

Appendix G (2)

Employee Consent to Hepatitis B Vaccine

On {Date}, I {Name} received information concerning the risk of occupational exposure to blood or other potentially infectious material in the position of {Job Title}, which has been determined as job classification exposure Category {I or II}. I have received a copy of the Hepatitis B information packet which has been explained to me and I understand this information.

I have been informed and understand (1) that Hepatitis B vaccination may reduce the potential risk of occupationally contracted viral hepatitis infection, and (2) the risks of the Hepatitis B vaccination which may include pain, itching, bruising at the injection site, sweating, weakness, chills, flushing and tingling, and (3) to obtain adequate immunity to viral Hepatitis B, it will be necessary to receive all three vaccinations of the vaccine series which are administered one month and six months after the initial vaccination, and (4) that the vaccination will be provided to me free of charge by {Name of Facility}. If at such future time the U.S. Public Health Service recommends a booster dose(s) of Hepatitis B vaccine, such booster dose(s) shall also be provided to me at no cost if I am employed by the facility in a job classification that involves some risk of an occupational exposure to blood or other potentially infectious materials.

If I leave the employment of this facility before the series is completed, it is my responsibility to contact my own medical provider to complete the vaccine series.

I hereby consent to the administration of the Hepatitis B vaccination and voluntarily acknowledge that:

I do not have an allergy to yeast.
I am not pregnant or nursing.
I am not planning to become pregnant within the next six months.
I have not had a fever, gastric symptoms, respiratory symptoms, or other signs of illness in the last 48 hours.
I do have the following known allergies:
Food: _____
Drugs: _____
Other: _____

YOU MAY WISH TO CONSULT WITH YOUR PHYSICIAN BEFORE TAKING THE VACCINE

_____ _____
(Employee Name and Social Security Number) (Date)

_____ _____
(Witness) (Date)

PLACE IN EMPLOYEE MEDICAL FILE

Appendix G (3)

Kansas Department of Health and Environment

Hepatitis B Vaccine Declination Statement (Previously Vaccinated)

I understand that due to my occupational exposure to blood or other potentially infectious materials that I may be at risk of acquiring hepatitis B virus infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to me. I decline the hepatitis B vaccine at this time because I received the complete hepatitis B vaccine series in the past.

Employee's name _____

Employee's signature _____

Bureau/Office _____

Date _____

Appendix H (1)

Post-exposure assessment and evaluation

Exposure Incident Investigation Form

Date of Incident: _____ Time of Incident: _____

Location: _____

Potentially Infectious Materials Involved:

Type: _____ Source: _____

_____ _____

Circumstances: {Work being performed, etc.} _____

_____

_____

How Incident Was Caused: {Accident, equipment malfunction, etc.}

_____

_____

_____

Personal Protective Equipment Used: _____

_____

Actions Taken: {Decontamination, clean-up, reporting, etc.}

_____

_____

Recommendations for Avoiding Repetition: _____

_____

_____

Appendix H (2)

Post-Exposure Evaluation and Follow-up Checklist

The following steps must be taken, and information transmitted to healthcare professional, in the event of an employee's exposure to Bloodborne Pathogen.

Activity	Completion Date

O Employee furnished with documentation regarding exposure incident: _____

O Source individual identified: _____
(Source Individual)

O Source individual's blood collected and results given to exposed employee: _____

_____ Consent from source has not been obtained.

O Exposed employee's blood collected and tested: _____

O Appointment arranged for employee with health care professional: _____

_____
(Healthcare Professional Name)

O Documentation forwarded to healthcare professional:
_____

_____ Bloodborne Pathogens Standard.
_____ Description of exposed employee's duties.
_____ Description of exposure incident, including exposure routes.
_____ Results of source individual's blood testing.
_____ Employee's medical records.

The Occupational Safety and Health Administration's (OSHA) Rule 29 CFR 1910.1030 (http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051) on bloodborne pathogens became effective March 6, 1992 and revisions were published January 18, 2001 to the "Federal Registers Occupational Exposure to Bloodborne Pathogens; Needlestick and Other Sharps Injuries; Final Rule. - 66:5317-5325 http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=FEDERAL_REGISTER&p_id=16265&p_text_version=FALSE).

NOTE: Paper copies of the standard are available by request: KDHE/HR (785) 296-1290.

Appendix I (1)

Hepatitis B Post-exposure prophylaxis recommendations

TABLE 3. Recommended postexposure prophylaxis for exposure to hepatitis B virus

Vaccination and antibody response status of exposed workers[*]	Treatment		
	Source HBsAg[†] positive	Source HBsAg[†] negative	Source unknown or not available for testing
Unvaccinated	HBIG[‡] x 1 and initiate HB vaccine series[¶]	Initiate HB vaccine series	Initiate HB vaccine series
Previously vaccinated			
Known responder[**,††]	No treatment	No treatment	No treatment
Known nonresponder[§§]	HBIG x 1 and initiate revaccination or HBIG x 2[¶¶]	No treatment	If known high risk source, treat as if source were HBsAg positive
Antibody response unknown	Test exposed person for anti-HBs[¶¶] 1. If adequate,[***] no treatment is necessary 2. If inadequate,[†] administer HBIG x 1 and vaccine booster	No treatment	Test exposed person for anti-HBs 1. If adequate,[†] no treatment is necessary 2. If inadequate,[†] administer vaccine booster and recheck titer in 1-2 months

[*] Persons who have previously been infected with HBV are immune to reinfection and do not require postexposure prophylaxis.

[†] Hepatitis B surface antigen.

[‡] Hepatitis B immune globulin; dose is 0.06 mL/kg intramuscularly.

[¶] Hepatitis B vaccine.

[**] A responder is a person with adequate levels of serum antibody to HBsAg (i.e., anti-HBs ≥10 mIU/mL).

[††] A nonresponder is a person with inadequate response to vaccination (i.e., serum anti-HBs < 10 mIU/mL).

[§§] The option of giving one dose of HBIG and reinitiating the vaccine series is preferred for nonresponders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred.

[¶¶] Antibody to HBsAg.

Appendix I (2)

HIV Post-exposure prophylaxis recommendations

TABLE 4. Recommended HIV postexposure prophylaxis for percutaneous injuries

	Infection status of source				
Exposure type	HIV-Positive Class 1*	HIV-Positive Class 2*	Source of unknown HIV status†	Unknown source§	HIV-Negative
Less severe¶	Recommend basic 2-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP** for source with HIV risk factors††	Generally, no PEP warranted; however, consider basic 2-drug PEP** in settings where exposure to HIV-infected persons is likely	No PEP warranted
More severe§§	Recommend expanded 3-drug PEP	Recommend expanded 3-drug PEP	Generally, no PEP warranted; however, consider basic 2-drug PEP** for source with HIV risk factors††	Generally, no PEP warranted; however, consider basic 2-drug PEP** in settings where exposure to HIV-infected persons is likely	No PEP warranted

* HIV-Positive, Class 1 — asymptomatic HIV infection or known low viral load (e.g., <1,500 RNA copies/mL). HIV-Positive, Class 2 — symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load. If drug resistance is a concern, obtain expert consultation. Initiation of postexposure prophylaxis (PEP) should not be delayed pending expert consultation, and, because expert consultation alone cannot substitute for face-to-face counseling, resources should be available to provide immediate evaluation and follow-up care for all exposures.

† Source of unknown HIV status (e.g., deceased source person with no samples available for HIV testing).

§ Unknown source (e.g., a needle from a sharps disposal container).

¶ Less severe (e.g., solid needle and superficial injury).

** The designation "consider PEP" indicates that PEP is optional and should be based on an individualized decision between the exposed person and the treating clinician.

†† If PEP is offered and taken and the source is later determined to be HIV-negative, PEP should be discontinued.

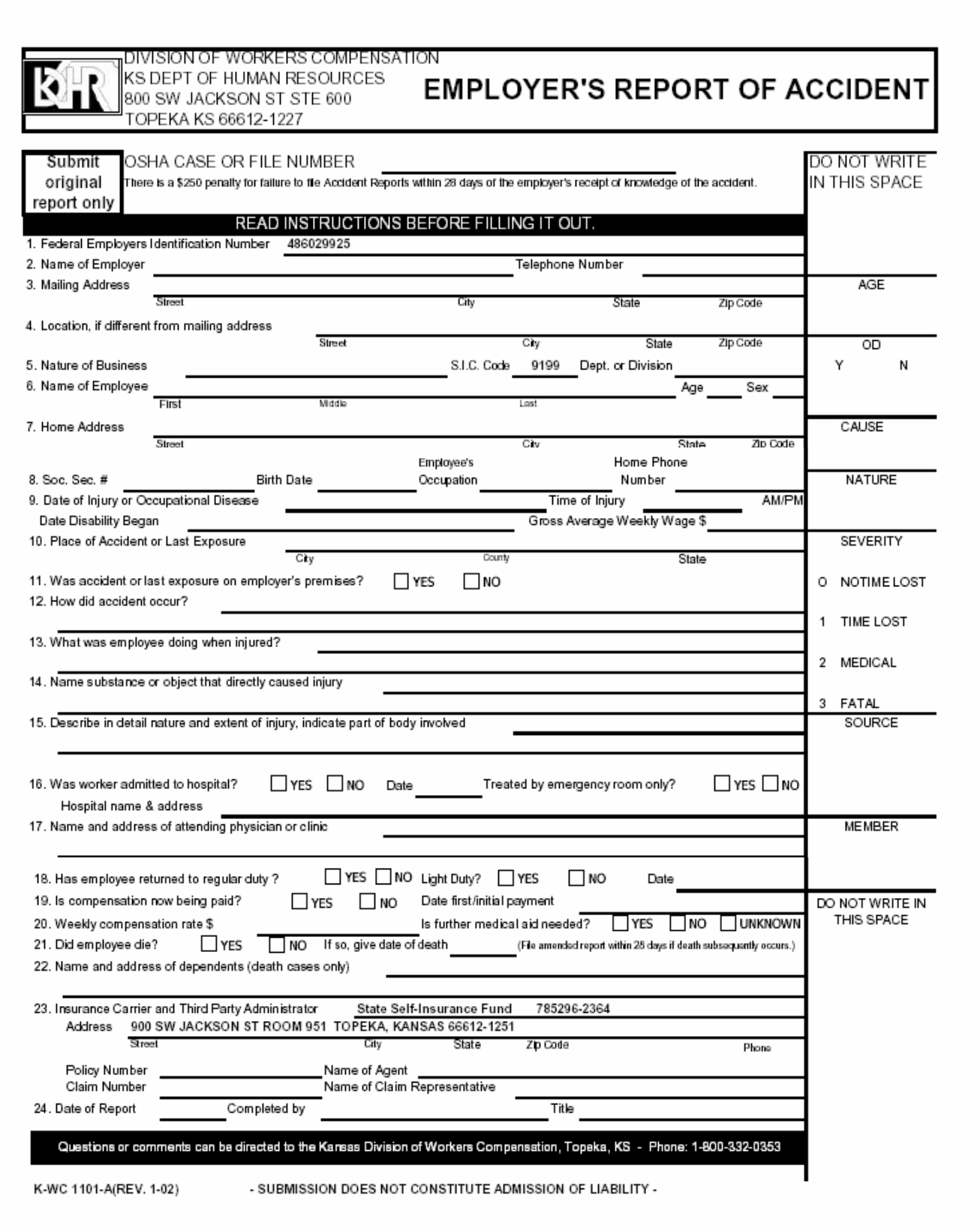
§§ More severe (e.g., large-bore hollow needle, deep puncture, visible blood on device, or needle used in patient's artery or vein).

(Tables and Figures from MMWR "Updated U.S. public health service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis", June 29, 2001; Vol. 50(RR11), 1-42)

Appendix J

Employer's report of accident form 1101-A

(Found at http://www.khpa.ks.gov/SSIF/kwc1101a(Rev-02-06).pdf ; or http://www.da.ks.gov/ps/documents/wc1101a.pdf)



DIVISION OF WORKERS COMPENSATION
KS DEPT OF HUMAN RESOURCES
800 SW JACKSON ST STE 600
TOPEKA KS 66612-1227

EMPLOYER'S REPORT OF ACCIDENT

Submit original report only

OSHA CASE OR FILE NUMBER

There is a $250 penalty for failure to file Accident Reports within 28 days of the employer's receipt of knowledge of the accident.

DO NOT WRITE IN THIS SPACE

READ INSTRUCTIONS BEFORE FILLING IT OUT.

1. Federal Employers Identification Number 486029925
2. Name of Employer _____ Telephone Number _____
3. Mailing Address _____ (Street, City, State, Zip Code)
4. Location, if different from mailing address _____ (Street, City, State, Zip Code)
5. Nature of Business _____ S.I.C. Code 9199 Dept. or Division _____
6. Name of Employee _____ (First, Middle, Last) Age ____ Sex ____
7. Home Address _____ (Street, City, State, Zip Code)
8. Soc. Sec. # _____ Birth Date _____ Employee's Occupation _____ Home Phone Number _____
9. Date of Injury or Occupational Disease _____ Time of Injury _____ AM/PM
   Date Disability Began _____ Gross Average Weekly Wage $ _____
10. Place of Accident or Last Exposure _____ (City, County, State)
11. Was accident or last exposure on employer's premises? ☐ YES ☐ NO
12. How did accident occur? _____
13. What was employee doing when injured? _____
14. Name substance or object that directly caused injury _____
15. Describe in detail nature and extent of injury, indicate part of body involved _____
16. Was worker admitted to hospital? ☐ YES ☐ NO Date _____ Treated by emergency room only? ☐ YES ☐ NO
    Hospital name & address _____
17. Name and address of attending physician or clinic _____
18. Has employee returned to regular duty ? ☐ YES ☐ NO Light Duty? ☐ YES ☐ NO Date _____
19. Is compensation now being paid? ☐ YES ☐ NO Date first/initial payment _____
20. Weekly compensation rate $ _____ Is further medical aid needed? ☐ YES ☐ NO ☐ UNKNOWN
21. Did employee die? ☐ YES ☐ NO If so, give date of death _____ (File amended report within 28 days if death subsequently occurs.)
22. Name and address of dependents (death cases only) _____
23. Insurance Carrier and Third Party Administrator State Self-Insurance Fund 785296-2364
    Address 900 SW JACKSON ST ROOM 951 TOPEKA, KANSAS 66612-1251 (Street, City, State, Zip Code, Phone)
    Policy Number _____ Name of Agent _____
    Claim Number _____ Name of Claim Representative _____
24. Date of Report _____ Completed by _____ Title _____

Questions or comments can be directed to the Kansas Division of Workers Compensation, Topeka, KS - Phone: 1-800-332-0353

K-WC 1101-A(REV. 1-02) - SUBMISSION DOES NOT CONSTITUTE ADMISSION OF LIABILITY -

AGE

OD Y N

CAUSE

NATURE

SEVERITY

0 NOTIME LOST
1 TIME LOST
2 MEDICAL
3 FATAL

SOURCE

MEMBER

DO NOT WRITE IN THIS SPACE

Appendix K

Designated Medical Care Providers

(Location http://da.state.ks.us/ps/subject/workcomp.htm; or http://www.khpa.ks.gov/subject/workcomp.htm)

Managed Care Facilities

The State Self Insurance Fund has designated medical care providers in certain areas. To receive authorized medical treatment, injured employees must be seen at these facilities (if within their area). In locations that do not have managed care facilities the employee should be seen by their primary care physician.

Topeka:	St. Francis Hospital & Medical Center 1700 SW 7th Street Topeka, KS 66606 (785) 295-8000
Kansas City:	University of Kansas Hospital Authority 3901 Rainbow Blvd. Kansas City, KS 66160 (913) 588-5000
Kansas City:	KU Med West 7405 Renner Road Shawnee, KS 66217 (913) 588-8400
Lawrence:	Lawrence Memorial Hospital 325 Maine Street Lawrence, KS 66044 (785) 749-6100
Manhattan:	Mercy West 315 Seth Child Manhattan, KS 66502 (785) 776-2813
Wichita:	Wichita Clinic Occupational Health Building 3311 E. Murdock Wichita, KS 67208 (316) 261-6183

Exposure Control Plan Committee Signature of Concurrence

RECEIVED
MAR 3 0 2007
HRM

State Epidemiologist

Director of the Division of Health

Director of the Division of Environment

Director of the Kansas Health and Environmental Laboratory

Safety Officer, Kansas Health and Environmental Laboratory

Director of Human Resources, Division of Management and Budget

Organizational Development, Division of Management and Budget

Kansas Department of Labor, Division of Industrial Safety and Health

KDHE Universal Laboratory Specimen Submission Form (Health)

6700 SW Topeka Blvd, Forbes Field Bldg. 740 | Topeka, KS 66620 CLIA 17DO648254
Fax: 785-296-1641 | Phone: 785-296-1620

FACILITY NAME BDCP-STI/HIV Program
FACILITY ADDRESS 1000 SW Jackson, Ste. 210 Topeka, KS 66612
FACILITY ID STI001
LABEL/COMMENTS: Patient Label

PATIENT INFORMATION (Required)

Last Name, First Doe, Jane
DOB 8-1-2014 Sex: ☐ Male ☑ Female ☐ Unknown
Race: ☑ White ☐ Asian ☐ AI, AN ☐ Black ☐ HN,PI
Ethnicity: ☑ Hispanic or Latino ☐ Non-Hispanic or Non Latino
Address 1234 Deer Creek Road
City Topeka State KS Zip 666619
MRN #
Medicaid#
Collection Date 8-4-2014 Collectors Last Name Green
Physician's Full Name Dr. Susan Mosier

DIAGNOSIS CODE/REASON (Required)

V74.5 (700, 200, 300) V73.89 (900)

Test Ordered/A-code (please check below)

DIAGNOSTIC MICROBIOLOGY:

☐ Tuberculosis
☐ *Culture w/smear* ☐ *Mycobacterium (Isolate ID)*

☐ Quantiferon: *Incubation (Date/Time (Required))*
*IN*_____/_____ *OUT*_____/_____ ☐ *Not Incubated*

Quantiferon Test Purpose:
☐ *College Contract* ☐ *Contact investigation*
☐ *Refugee* ☐ *Screening Contract*
☐ *Other*_____

☐ Fecal Ova/Parasite ☐ Worm (ID)
(add) ☐ *Cryptosporidium* ☐ *Cyclospora*

☐ Bacterial Isolate (ID only) specify_____
☐ *GNR* ☐ *GNC* ☐ *GPR* ☐ *GPC*
☐ *Rule out select agent* ☐ *STEC confirmation/ID (stool in broth)*

☐ Enteric Stool Screen, Routine *(includes analysis for: Salmonella, Shigella, Shiga toxin E.coli, and Campylobacter)*
(add) ☐ *Yersinia* ☐ *Vibrio* ☐ *Other*_____

TOXICOLOGY

☐ Blood Metals: Lead, Mercury, Cadmium
(Whole Blood EDTA)

SPECIMEN SOURCE / MATRIX — KHEL use only

☑ Blood	☐ Serum
☐ Bronchial Wash	☐ Sputum
☐ CSF	☐ Stool
☐ Endocervical	☐ Urethral
☐ Genital	☑ Urine
☐ Nasopharyngeal	☐ Vaginal
☐ Plasma	☐ Wound
☐ Other_____	

SEROLOGY/ VIROLOGY / MOLECULAR

☑ HIV (Authorized sites only)
Prior Confirmation Date _____
☐ Hepatitis B
☐ Hepatitis C
☐ Rubella (Spun/Ship Cold)
☑ Syphilis
*Prior Reactives Date*_____
☑ Chlamydia/Gonorrhea ☐ Endocervical/Urethral ☑ Urine ☐ Vaginal
☐ Herpes
☐ Influenza (ILI sites) ☐ hospitalized_____

APPROVAL REQUIRED BY:EPI HOTLINE 1-877-427-7317

Epi Approved _____

☐ Hepatitis A (IgM)	☐ Measles
☐ *Perinatal-PVST*	☐ *PCR* ☐ *IgG* ☐ *IgM*
☐ Norovirus (PCR)	☐ Mumps
	☐ *PCR* ☐ *IgG* ☐ *IgM*
☐ Pertussis (PCR)	☐ Varicella (PCR)
☐ West Nile Virus (IgM)	

Date of Onset _____
Test for (Specify) _____

BIOLOGICAL TESTING: POST EXPOSURE

☐ Food Source ☐ Environmental Source
Test for (Specify) _____

CHEMICAL TESTING: POST EXPOSURE *Chain of custody required*

☐ Cyanide ☐ VOC's *- Whole Blood ONLY* ☐ Nerve Agent Metabolites *- Urine ONLY*
☐ Toxic Metals *(Specimen Type - choose one)* ☐ Abrin/Ricin ☐ Tetramine *- Urine ONLY*
☐ *Urine* ☐ *Whole Blood*
☐ MTP ☐ Other _____

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30363508

BIS Investigative Resources:

1. **Facebook** – your virtual "address" – a good place to check first. Having a photo to reference will help when completing the IX with the OP so that you can verify you have the correct individual.
    a. Search in FB: "People named Scott in Manhattan, Kansas"
    b. Search all the people with that name, look for where they live, mutual friends, etc. in order to make a match.
    c. If looking for a contact (P1, P2, P3, A3, etc .) – Search the OP's FB Friends – they may be friends and this is an easy way to find the correct person.
    d. Look at the Timeline – Where they work, who they are in a relationship with, family members, birthday, etc. may be here.
    e. Look at the About Tab and all of the items in this section to find out more about the pt.
    f. Look through photos of who they are with and comments made – it's amazing what you can find out by going through photos and reading comments (phone numbers left in the comment section of photos, "Happy Birthday" wishes, partner's names, dates of connections, etc.). Priceless.

2. **Google** – name, name and school, name and city, etc. – You never know what you may find here!
    a. **Google Maps** – Look for the address before you go out or view during IX to find an address.
    b. **Local News** – If the patient has a known history of criminal behavior, try adding the word "arrest" to the search terms for name and city. Many areas have newspapers or television stations that list arrest calls and police blotters that can provide information like DOB and addresses.
    c. **Obituaries** – Almost everyone has a family, and when family members pass away, survivors are often listed in obituaries. This can provide names of siblings, parents and other family members that could be searched for in order to find people to ask about the patient's whereabouts or updated contact information.
    d. **Image searches** – If you are able to locate an image or picture of the person that you are looking for, it is possible to search Google for that image in order to find other sites on the web that also host the image. A good example of this would be a profile pic from someone's Facebook page: there is a good chance that the same image will be used as a profile pic on other social networking or dating sites.

3. **School Directories** (or just call your contact at the student health facility):
    a. KSU: http://search.k-state.edu/?qt=&curtab=1
    b. KU: https://myidentity.ku.edu/directory/search

Last updated: 2/9/2015
Elise Dunnigan

4. **Department of Corrections** for Kansas: http://www.doc.ks.gov/kasper

5. **White Pages**: http://www.whitepages.com/

6. Your **Local Health Department** or the Health Department in the county they live/have lived in.

7. The **hospital** in the area they live.

8. **Other Health Department Records** – i.e. Women with young children may be in WIC or if you know their child's name (i.e. FB research) you can find their child through immunizations and therefore find mom.

9. Talking to their **neighbors**…

10. Where do they **work** or have worked – talking with current or former coworkers can give you insight on how to find them or a new cell phone number.

11. **Local Jails** or correctional institutions.

12. **Kansas Offender Search:** http://www.kbi.ks.gov/registeredoffender/

13. **National Offender Search:** http://www.nsopw.gov/?AspxAutoDetectCookieSupport=1

14. **Lexis Nexis** – Request a Search. Look through addresses, names of whom they have lived with, family members, etc.

15. **Spokeo** – Another search you can request (usually complete with LN search).

16. **Other Websites** that they may belong to – should be asked during the IX.

17. **KHIN** (Kansas Health Information Network) – Information may be posted if their provider participates. A great place to start. Search for pt's info., emergency contacts, previous addresses, reasons for services, etc. Try "advanced search" with DOB (or best guess) & gender for better results.

Kansas
Department of Health and Environment

Outbreak Response Plan
STI/HIV Section
Disease Intervention Program

I. **Purpose**: To provide the STI/HIV Disease Intervention Program Management with a standardized method to evaluate and respond to STIs (including HIV) during potential outbreak situations. The Outbreak Response Plan (ORP) is utilized to manage the redirection of resources, alteration of priorities, intensification of surveillance systems, and initiation or improvement of coordination among local, state, and federal public health agencies.

II. **Identification:** The STI/HIV Section receives positive laboratory reports on all reportable infections under the purview of the program and uses this data to monitor disease trends. This passive surveillance system is used to identify increases in morbidity by geographic areas (zip codes, cities, and counties) by comparing the data with historical data from previous years. Identifying an increase above endemic levels will prompt program management and area supervisors to initiate an analysis of the data to determine if the increase represents an outbreak or if the increase is part of the normal distribution of disease in the population.

A. The following thresholds have been established to determine appropriate responses to reported increases in STI morbidity throughout Kansas:
Cluster: An increase in morbidity in any geographically defined area ranging between 10-19% for a given time frame OR upon identifying 5 cases (or 3 linked cases) of early syphilis or HIV in a county within a 30 day period OR upon identifying 1 case of cephlasporin-resistant gonorrhea. The cluster classification can be upgraded to outbreak classification at the time the thresholds meets the requirements, or at any time at the discretion of Section Management.

Outbreak: An increase in morbidity over 19% in any geographically defined area for a given time frame when compared to the same geographic area and a corresponding time frame. (i.e. January-June of 2014 compared to January-June of 2015).

III. Response:

A. Alteration of Priorities:

1. Once a cluster or outbreak has been identified and the decision to initiate the ORP has been determined, the STI/HIV Section will initiate “cluster protocol” for the affected area(s), including all field staff who are assigned to work the

cluster/outbreak. Cluster protocol alleviates affected field staff from completing lower-priority investigations.

B. Redirection of resources

1. Central office will continue to process laboratory reports daily, query clinics and private providers by telephone for treatment and locating information, and assign confirmed, suspected and contact cases needing follow-up to the corresponding Behavioral Intervention Specialist (BIS).
2. The amount of staff needed during cluster/outbreak conditions will be determined by the number of cases beyond the designated threshold, location of the outbreak, local health department resources, and other factors unique to the outbreak. Local BIS contracts stipulate that BIS may be temporarily assigned to another area of the state for the duration of any identified outbreaks.
3. A state epidemiologist from the Bureau of Epidemiology and Public Health Informatics Services may be consulted during outbreak conditions to provide technical assistance regarding enhanced surveillance, outbreak measures, and data analysis.

C. Intensification of Surveillance Systems:

1. During cluster or outbreak conditions, central office staff (Topeka) will contact all laboratories within the outbreak area to obtain positive test results of the specified outbreak disease.
2. During outbreak conditions, daily meetings (Chalk Talks) of BIS and Program Management will be held to coordinate case investigations, surveillance, and interviewing activities either in person, by phone, or through approved internet meetings. These meetings will focus on gathering information on common risk factors, demographics, geographic location, and/or venues for partner selection of all identified cases.
3. STI/HIV Disease Intervention Program Staff will utilize information obtained from daily Chalk Talks to initiate active surveillance systems to identify new cases including community outreach, provider outreach, and enhanced partner services activities depending on available information.
4. During cluster/outbreak conditions, the STI/HIV Section will utilize GIS mapping services to produce visual representations of disease morbidity (and contacts, if appropriate) to identify specific areas of higher disease incidences/prevalence.

D. Improvement of coordination among local, state, and federal Public Health agencies

1. The STI/HIV Section will contact all appropriate stakeholders (local health departments, private providers, community-based organizations, federal partners, etc.) as soon as an outbreak has been identified and maintain contact with them throughout the outbreak response. The stakeholders that will be involved will depend on the causative agent, identified risk factors, as well as the location of the outbreak.
2. The assigned CDC Project Officer will be contacted within 24 hours of identification of a cluster/outbreak. The CDC project officer will be given all pertinent information regarding the outbreak, provided daily updates, and invited to attend all after-action reporting.
3. Confidentiality must continue to be maintained at the highest levels, and organizations outside of KDHE will only be provided specific, detailed information on a need-to-know basis. All information that is provided outside of the STI/HIV Section must have prior approval by the STI/HIV Section Chief and the Bureau of Disease Control and Prevention Director.
4. Contact with the media should be made by the local health departments unless a large outbreak occurs that requires interaction between the KDHE and the media. Communication with the media must comply with all KDHE policies, and will be arranged by Section and Bureau Management with the KDHE Office of Communications.
5. Upon the conclusion of the outbreak response, all parties involved with the outbreak response will be invited and encouraged to participate in the After Action Report. The After Action Report (AAR) will be conducted upon conclusion of the outbreak response to determine the effectiveness of the response and identify areas for improvement, both in process and outcomes.

IV. Special Considerations-Multiple Clusters/Outbreaks

A. Prioritization-In the event that multiple clusters/outbreaks are occurring simultaneously, investigations will be prioritized first by disease, then by geographic area and number of identified cases. Disease priority is as follows:

1. Early Syphilis
2. HIV
3. Cephlasporin-resistant Gonorrhea

B. Resources-Current state and contractual BIS will be re-assigned to cluster/outbreak investigations based on prioritization. BIS in adjacent geographic areas and areas of lowest morbidity will be re-assigned first. Staffing capacity allows for 11 BIS, and 4 management staff with BIS experience for re-assignment. Once these resources have been utilized, additional resources at the county and local levels will be utilized as necessary.

REGULATIONS & STATUTES:

The following is a brief overview of commonly used regulations and statutes, and does not represent all regulations and/or statutes that may relate to STDs and HIV. For complete information on regulation or statutes, please visit the Kansas Legislature website at:
http://www.kslegislature.org/legsrv-legisportal/index.do

AUTHORITY TO PROVIDE FIELD SERVICES:

65-101. Health supervision; investigation of causes of disease, sickness and death; sanitation inspections; prevention of spread of disease; outreach services; rules and regulations; injunction. (a)

The secretary of health and environment shall exercise general supervision of the health of the people of the state and may:

(1) Where authorized by any other statute, require reports from appropriate persons relating to the health of the people of the state so a determination of the causes of sickness and death among the people of the state may be made through the use of these reports and other records;

(2) investigate the causes of disease, including especially, epidemics and endemics, the causes of mortality and effects of locality, employments, conditions, food, water supply, habits and other circumstances affecting the health of the people of this state and the causes of sickness and death;

(3) advise other offices and agencies of government concerning location, drainage, water supply, disposal of excreta and heating and ventilation of public buildings;

(4) make sanitary inspection and survey of such places and localities as the secretary deems advisable;

(5) take action to prevent the introduction of infectious or contagious disease into this state and to prevent the spread of infectious or contagious disease within this state;

(6) provide public health outreach services to the people of the state including educational and other activities designed to increase the individual's awareness and appropriate use of public and other preventive health services.

(b) The secretary of health and environment may adopt rules and regulations necessary to carry out the provisions of paragraphs (1) through (6), inclusive, of subsection (a). In addition to other remedies provided by law, the secretary is authorized to apply to the district court, and such court shall have jurisdiction upon a hearing and for cause shown to grant a temporary or permanent injunction to compel compliance with such rules and regulations.

History: L. 1885, ch. 129, § 4; L. 1907, ch. 379, § 1; R.S. 1923, 65-101; L. 1974, ch. 352, § 1; L. 1981, ch. 240, § 1; L. 1989, ch. 184, § 1; July 1.

GENERAL DISEASE REPORTING REQUIREMENTS:

65-118. Reporting to local health authority as to infectious or contagious diseases; persons reporting; immunity from liability; confidentiality of information; disclosure. (a) Whenever any person licensed to practice the healing arts or engaged in a postgraduate training program approved by the state board of healing arts, licensed dentist, licensed professional nurse, licensed practical nurse[,] administrator of a hospital, licensed adult care home-administrator, licensed physician assistant, licensed social worker, teacher or school administrator knows or has information indicating that a person is suffering from or has died from a reportable infectious or contagious disease as defined in rules and regulations, such knowledge or information shall be reported immediately to the county or joint board of health or the local health officer, together with the name and address of the person who has or is suspected of having the infectious or contagious disease, or the name and former address of the deceased individual who had or was suspected of having such a disease. In the case of a licensed hospital or adult care home, the administrator may designate an individual to receive and make such reports. The secretary of health and environment shall, through rules and regulations, make provision for the consolidation of reports required to be made under this section when the person required to make the report is working in a licensed hospital or adult care home. Laboratories certified under the federal clinical laboratories improvement act pursuant to 42 code of federal regulations, 493 shall report the results of microbiologic cultures, examinations, immunologic essays for the presence of antigens and antibodies and any other laboratory tests which are indicative of the presence of a reportable infectious or contagious disease to the department of health and environment. The director of the division of public health may use information from death certificates for disease investigation purposes.

(b) Any person who is an individual member of a class of persons designated under subsection (a) of this section and who reports the information required to be reported under such subsection in good faith and without malice to a county or joint board of health, a local health officer or the department of health and environment shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such report. Any such person shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

(c) Information required to be reported under subsection (a) of this section shall be confidential and shall not be disclosed or made public, upon subpoena or otherwise, beyond the requirements of subsection (a) of this section or subsection (a) of K.S.A. 65-119, and amendments thereto, except such information may be disclosed: (1) If no person can be identified in the information to be disclosed and the disclosure is for statistical purposes;

(2) if all persons who are identifiable in the information to be disclosed consent in writing to its disclosure;

(3) if the disclosure is necessary, and only to the extent necessary, to protect the public health;

(4) if a medical emergency exists and the disclosure is to medical personnel qualified to treat infectious or contagious diseases. Any information disclosed pursuant to this paragraph shall be disclosed only to the extent necessary to protect the health or life of a named party; or

(5) if the information to be disclosed is required in a court proceeding involving child abuse and the information is disclosed in camera.

History: L. 1901, ch. 285, § 2; R.S. 1923, 65-118; L. 1953, ch. 283, § 1; L. 1976, ch. 262, § 1; L. 1979, ch. 189, § 1; L. 1998, ch. 35, § 1; L. 2000, ch. 162, § 17; L. 2013, ch. 59, § 2; July 1.

Revisor's Note:

Apparently there should be a comma following "licensed practical nurse" and preceding "administration of a hospital" in subsection (a).

PROPHYLACTIC TREATMENT OF NEWBORN INFANTS

65-153. Child hygiene; duties of division of public health. The general duties of the division of public health of the department of health and environment shall include the issuance of educational literature on the care of the baby and the hygiene of the child, the study of the causes of infant mortality and the application of preventive measures for the prevention and the suppression of the diseases of infancy and early childhood.

History: L. 1915, ch. 269, § 2; R.S. 1923, 65-153; L. 1974, ch. 352, § 13; L. 2013, ch. 59, § 3; July 1.

TREATMENT OF MINORS

65-2892. Examination and treatment of persons under 18 for venereal disease; liability. Any physician, upon consultation by any person under eighteen (18) years of age as a patient, may, with the consent of such person who is hereby granted the right of giving such consent, make a diagnostic examination for venereal disease and prescribe for and treat such person for venereal disease including prophylactic treatment for exposure to venereal disease whenever such person is suspected of having a venereal disease or contact with anyone having a venereal disease. All such examinations and treatment may be performed without the consent of, or notification to, the parent, parents, guardian or any other person having custody of such person. Any physician examining or treating such person for venereal disease may, but shall not be obligated to, in accord with his opinion of what will be most beneficial for such person, inform the spouse, parent, custodian, guardian or fiance of such person as to the treatment given or needed without the consent of such person. Such informing shall not constitute libel or slander or a violation of the right of privacy or privilege or otherwise subject the physician to any liability whatsoever. In any such case, the physician shall incur no civil or criminal liability by reason of having made such diagnostic examination or rendered such treatment, but such immunity shall not apply to any negligent acts or omissions. The physician shall incur no civil or criminal liability by reason of any adverse reaction to medication administered, provided reasonable care has been taken to elicit from such person under eighteen (18) years of age any history of sensitivity or previous adverse reaction to the medication.

History: L. 1969, ch. 222, § 1; L. 1972, ch. 161, § 17; July 1.

HIV/AIDS STATUTES

65-6001. Definitions. As used in K.S.A. 65-6001 to 65-6007, inclusive, and K.S.A. 65-6008, 65-6009 and 65-6010, and amendments thereto, unless the context clearly requires otherwise:

(a) "AIDS" means the disease acquired immune deficiency syndrome.

(b) "HIV" means the human immunodeficiency virus.

(c) "Laboratory confirmation of HIV infection" means positive test results from a confirmation test approved by the secretary.

(d) "Secretary" means the secretary of health and environment.

(e) "Physician" means any person licensed to practice medicine and surgery.

(f) "Laboratory director" means the person responsible for the professional, administrative, organizational and educational duties of a laboratory.

(g) "HIV infection" means the presence of HIV in the body.

(h) "Racial/ethnic group" shall be designated as either white, black, Hispanic, Asian/Pacific islander or American Indian/Alaskan Native.

(i) "Corrections officer" means an employee of the department of corrections as defined in subsections (f) and (g) of K.S.A. 75-5202, and amendments thereto.

(j) "Emergency services employee" means an attendant as defined under K.S.A. 65-6112, and amendments thereto, or a firefighter.

(k) "Law enforcement employee" means:

(1) Any police officer or law enforcement officer as defined under K.S.A. 74-5602, and amendments thereto;

(2) any person in the service of a city police department or county sheriff's office who performs law enforcement duties without pay and is considered a reserve officer;

(3) any person employed by a city or county who is in charge of a jail or section of jail, including jail guards and those who conduct searches of persons taken into custody; or

(4) any person employed by a city, county or the state of Kansas who works as a scientist or technician in a forensic laboratory.

(l) "Employing agency or entity" means the agency or entity employing a corrections officer, emergency services employee, law enforcement employee or jailer.

(m) "Infectious disease" means AIDS.

(n) "Infectious disease tests" means tests approved by the secretary for detection of infectious diseases.

(o) "Juvenile correctional facility staff" means an employee of the juvenile justice authority working in a juvenile correctional facility as defined in K.S.A. 2014 Supp. 38-2302, and amendments thereto.

History: L. 1988, ch. 232, § 1; L. 1990, ch. 234, § 1; L. 1996, ch. 215, § 1; L. 1998, ch. 187, § 12; L. 1999, ch. 109, § 1; L. 2006, ch. 169, § 119; L. 2010, ch. 119, § 17; Jan. 15, 2011.

65-6002. Reporting to secretary of health and environment information concerning AIDS or HIV infection; information reported, when; persons reporting; immunity from liability; confidentiality of information; disclosure; use of information to discriminate prohibited. (a) Whenever any physician has information indicating that a person is suffering from or has died from AIDS, such knowledge or information shall be reported immediately to the secretary, together with the name and address of the person who has AIDS. Any physician or administrator of a medical care facility or such administrator's designee who is in receipt of a report indicating laboratory confirmation of HIV infection resulting from the examination of any specimen provided to a laboratory by such physician or administrator or designee shall report all such information to the secretary. Reports shall be provided within 30 days of testing and shall include the name and address of the person tested, the type of test or tests performed, the date of performance of the test or tests, the results of the test or tests, the sex, date of birth, county of residence and racial/ethnic group of the person tested.

(b) Whenever any laboratory director has information on laboratory confirmation of HIV infection, this information shall be reported to the secretary. Reports shall be provided within 30 days of testing and shall include the type of test or tests, the results of the test or tests, dates of performance of the test or tests, the name of the physician or facility requesting the test or tests, and any identifying information about the person tested as the laboratory director has access to, such as the name and address of the person tested, the sex, date of birth, county of residence and racial/ethnic group, exposure category and pregnancy status of the person tested.

(c) Any physician, administrator of a medical care facility or such administrator's designee or laboratory director who reports the information required to be reported under subsection (a) or (b) in good faith and without malice to the secretary shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such report. Any such physician, administrator or designee or laboratory director shall have the same immunity with respect to participation in any judicial proceeding resulting from such report.

(d) Information required to be reported under subsection (a) or (b) and information obtained through laboratory tests conducted by the department of health and environment relating to HIV or AIDS and persons suffering therefrom or infected therewith shall be confidential and shall not be disclosed or made public, upon subpoena or otherwise, beyond the disclosure necessary under subsection (a) or (b) or under subsection (a) of K.S.A. 65-6003 and amendments thereto or the usual reporting of laboratory test results to persons specifically designated by the secretary as authorized to obtain such information, except such information may be disclosed:

(1) If no person can be identified in the information to be disclosed and the disclosure is for statistical purposes;

(2) if all persons who are identifiable in the information to be disclosed consent in writing to its disclosure;

(3) if the disclosure is necessary, and only to the extent necessary, as specified by rules and regulations of the secretary, to protect the public health;

(4) if a medical emergency exists and the disclosure is to medical personnel qualified to treat AIDS or HIV infection, except that any information disclosed pursuant to this paragraph shall be disclosed only to the extent necessary to protect the health or life of a named party; or

(5) if the information to be disclosed is required in a court proceeding involving a minor and the information is disclosed in camera.

(e) Information regarding cases of AIDS or HIV infection reported in accordance with this section shall be used only as authorized under this act. Such information shall not be used in any form or manner which would lead to the discrimination against any individual or group with regard to employment, to provision of medical care or acceptance into any facilities or institutions for medical care, housing, education,

transportation, or for the provision of any other goods or services.

History: L. 1988, ch. 232, § 2; L. 1990, ch. 234, § 2; L. 1997, ch. 8, § 14; L. 1999, ch. 109, § 2; L. 2001, ch. 58, § 1; July 1.

65-6003. Investigation of cases of AIDS or HIV infection; rules and regulations; protection of public health; disclosure of information; confidentiality; agreements with local boards of health authorized. (a) The secretary shall investigate cases of persons who have HIV infection or AIDS and monitor such cases during their continuance. The secretary may adopt and enforce rules and regulations for the prevention and control of HIV infection or AIDS as may be necessary to protect the public health. The secretary shall adopt rules and regulations for maintaining confidentiality of information under this act which at a minimum are as strict as the centers for disease control and prevention guidelines.

(b) Any information relating to persons who have HIV infection or AIDS which is required to be disclosed or communicated under subsection (a) shall be confidential and shall not be disclosed or made public beyond the disclosure necessary under subsection (a) or under subsection (a) of K.S.A. 65-6002 and amendments thereto to persons specifically designated by the secretary as authorized to obtain such information, except as otherwise permitted by subsection (d) of K.S.A. 65-6002 and amendments thereto.

(c) The secretary may enter into agreements with any county or joint board of health to perform duties required to be performed by the secretary under subsection (a) as specified by such agreement. The confidentiality requirements of subsection (b) shall apply to any duties performed pursuant to such an agreement

65-6004. Physician authorized to disclose to certain persons information about patient who has infectious disease or who has had laboratory confirmation of a positive reaction to an infectious disease test; confidentiality of information; immunity in judicial proceedings. (a) Notwithstanding any other law to the contrary, a physician performing medical or surgical procedures on a patient who the physician knows has an infectious disease or has had laboratory confirmation of a positive reaction to an infectious disease test may disclose such information to other health care providers, emergency services employees, corrections officers or law enforcement employees who have been or will be placed in contact with body fluids of such patient. The information shall be confidential and shall not be disclosed by such health care providers, emergency services employees, corrections officers or law enforcement employees except as may be necessary in providing treatment for such patient.

(b) Notwithstanding any other law to the contrary, a physician who has reason to believe that the spouse or partner of a person who has had laboratory confirmation of HIV infection or who has AIDS may have been exposed to HIV and is unaware of such exposure may inform the spouse or partner of the risk of exposure. The information shall be confidential and shall not be disclosed by such spouse or partner to other persons except to the spouse or partner who has had laboratory confirmation of HIV infection or who has AIDS.

(c) Nothing in this section shall be construed to create a duty to warn any person of possible exposure to HIV.

(d) Any physician who discloses or fails to disclose information in accordance with the provisions of this section in good faith and without malice shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such disclosure. Any such physician shall have the same immunity with respect to participation in any judicial proceeding resulting from such disclosure.

History: L. 1988, ch. 232, § 4; L. 1990, ch. 234, § 3; L. 1993, ch. 221, § 1; L. 1996, ch. 215, § 2; L. 1999, ch. 109, §

4; July 1.

65-6005. Unlawful acts; penalties. Except as otherwise provided in this section, any person violating, refusing or neglecting to obey any provision of K.S.A. 65-6001 through 65-6004, and amendments thereto, or of the rules and regulations adopted by the secretary for the prevention and control of HIV infection or AIDS shall be guilty of a class C misdemeanor. Any person who discloses information which is made confidential and prohibited from disclosure under K.S.A. 65-6002 through 65-6004, and amendments thereto, shall be guilty of a misdemeanor punishable by a fine of not less than $500 nor more than $1,000 and by imprisonment in the county jail for not more than six months.

History: L. 1988, ch. 232, § 5; L. 1999, ch. 109, § 5; July 1.

65-6006. Educational material explaining AIDS; distribution to district courts; copies provided to parties applying for marriage license. The secretary shall prepare for distribution to the district courts of the state educational material explaining the nature, causes and effects of AIDS and other information relating to AIDS as may be appropriate. The clerks of the district courts or judges thereof, when applied to for a marriage license, shall provide copies of such educational material to the parties to the proposed marriage.

65-6007. Establishment and maintenance of sites for testing for HIV. The secretary shall establish and maintain test sites throughout the state where testing for HIV may be undertaken including anonymous testing. The secretary shall establish test sites throughout the state so that an anonymous test site is available within 100 miles of any resident of the state.

65-6008. Infectious disease testing; certain persons in contact with body fluids; hearing; disclosure of test results. (a) If a corrections officer, emergency services employee , law enforcement employee or juvenile correctional facility staff comes in contact with or otherwise is exposed to transmission of body fluids from one or more other persons while performing duties within the scope of such employee's duties as an employee, the head of the employing agency or entity may make application to a court of competent jurisdiction for an order requiring such other person or persons to submit to infectious disease tests.

(b) Such application shall include an allegation that the person or persons sought to be tested have been requested to submit voluntarily to infectious disease tests and have refused the tests. When any such application is received, the court shall hold a hearing forthwith and shall issue its order thereon immediately if the court finds that: (1) There is probable cause to believe that the employee involved has come in contact with or otherwise has been exposed to transmission of the body fluids of the person or persons sought to be tested; and (2) the person or persons sought to be tested have been requested to submit to the tests and have refused, unless the court makes a further finding that exigent circumstances exist which , in the court's judgment, would excuse the applicant from making such a request.

(c) If an infectious disease test ordered pursuant to this section results in a negative reaction, the court shall order the person tested to submit to another infectious disease test six months from the date the first test was administered.

(d) The results of any infectious disease test ordered pursuant to this section shall be disclosed to the court which ordered the test, the employee and the person tested. If an infectious disease test ordered pursuant to this section results in a positive reaction, the results shall be reported to the employee.

History: L. 1996, ch. 215, § 3; L. 1998, ch. 187, § 13; July 1.

65-6009. Same; persons arrested or convicted; disclosure of test results; costs of counseling and testing. (a) At the time of an appearance before a magistrate under K.S.A. 22-2901 and amendments thereto, the magistrate shall inform any person arrested and charged with a crime in which it appears from the nature of the charge that the transmission of body fluids from one person to another may have been involved of the availability of infectious disease tests and shall cause the alleged victim of such a crime, if any, to be notified that infectious disease tests and counseling are available. If the victim of the crime or the county or district attorney requests the court to order infectious disease tests of the alleged offender or if the person arrested and charged with a crime stated to the law enforcement officer making such arrest that the person arrested and charged with the crime has an infectious disease or is infected with an infectious disease, or used words of like effect, the court shall order the arrested person to submit to infectious disease tests. The results of any test obtained under this section shall be inadmissible in any criminal or civil proceeding.

(b) Upon conviction of a person for any crime which the court determines from the facts of the case involved or was likely to have involved the transmission of body fluids from one person to another, the court: (1) May order the convicted person to submit to infectious disease tests; or (2) shall order the convicted person to submit to infectious disease tests if the victim of the crime or the parent or legal guardian of the victim, if the victim is a minor, requests the court to issue such order. If infectious disease tests are ordered under this subsection, the victim of the crime, if any, who is not a minor, shall designate a health care provider or counselor to receive such information on behalf of the victim. If the victim is a minor, the parent or legal guardian of the victim shall designate the health care provider or counselor to receive such information.

(c) The results of any infectious disease test ordered under subsection (a) shall be disclosed to the law enforcement officer making such arrest, the person arrested and such other persons as the court determines have a legitimate need to know the test result in order to provide for their protection. The results of any infectious disease test ordered under subsection (b) shall be disclosed to the court which ordered the test, the convicted person and to the person designated under subsection (b) by the victim or victims of the crime or by the parent or legal guardian of a victim if the victim is a minor. If an infectious disease test ordered under this section results in a positive reaction, the results shall be reported to the secretary of health and environment and to the secretary of corrections.

(d) As used in this section, infectious disease includes HIV and hepatitis B.

(e) The costs of any counseling and testing provided under this section shall be paid from amounts appropriated to the department of health and environment for that purpose. The court shall order the adjudicated person to pay restitution to the department of health and environment for the costs of any counseling provided under this section and the costs of any test ordered or otherwise performed under this section.

History: L. 1996, ch. 215, § 4; L. 2001, ch. 102, § 5; July 1.

65-6010. Same; withdrawal of blood; confidentiality of information; penalty. (a) When a court orders a person to submit to infectious disease tests under this act, the withdrawal of the blood may be performed only by: (1) A person licensed to practice medicine and surgery or a person acting under the supervision of any such licensed person; (2) a licensed professional nurse or a licensed practical nurse; or (3) a qualified medical technician. No person authorized by this subsection to withdraw blood, no person assisting in the performance of the infectious disease tests nor any medical care facility where blood is withdrawn or tested that has been ordered by the court to withdraw or test blood shall be liable in any civil or criminal action when the act is performed in a reasonable manner according to generally accepted medical practices.

(b) The results of tests or reports, or information therein, obtained under this act shall be confidential and shall not be divulged to any person not authorized by this act to receive the same. Any violation of this subsection is a class C nonperson misdemeanor.

65-6011. Report to legislature. On or before January 8, 2001, and annually thereafter, the secretary of health and environment shall report to the legislature concerning the impact of the changes made to K.S.A. 65-6001 through 65-6007, and amendments thereto.

65-6015. Definitions. As used in K.S.A. 65-6015 through 65-6017, and amendments thereto:

(a) "Body fluid" means blood, amniotic fluid, pericardial fluid, pleural fluid, synovial fluid, cerebrospinal fluid, semen or vaginal secretions, or any body fluid visibly contaminated with blood.

(b) "Corrections employee" means an employee of the juvenile justice authority or the department of corrections or an employee of a contractor who is under contract to provide services in a correctional institution.

(c) "Offender" means a person in the legal custody of the commissioner of juvenile justice or the secretary of corrections.

(d) "Physician" means any person licensed to practice medicine and surgery.

(e) "Infectious disease" means any disease communicable from one person to another through contact with bodily fluids.

History: L. 1993, ch. 221, § 2; L. 2001, ch. 102, § 1; L. 2005, ch. 40, § 1; July 1.

65-6016. Physician authorized to disclose infectious diseases to certain corrections employees; confidentiality; immunity in judicial proceedings. (a) Notwithstanding any other law to the contrary, a physician performing medical or surgical procedures on a patient who the physician knows has an infectious disease or has had a positive reaction to an infectious disease test may disclose such information to corrections employees who have been or will be placed in contact with body fluid of such patient. The information shall be confidential and shall not be disclosed by corrections employees except as may be necessary in providing treatment for such patient. Any other disclosure of such information by a corrections employee is a class C misdemeanor.

(b) Nothing in this section shall be construed to create a duty to warn any person of possible exposure to an infectious disease.

(c) Any physician who discloses information in accordance with the provisions of this section in good faith and without malice shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed in an action resulting from such disclosure. Any such physician shall have the same immunity with respect to participation in any judicial proceeding resulting from such disclosure.

History: L. 1993, ch. 221, § 3; L. 2001, ch. 102, § 2; July 1.

65-6017. Court ordered testing of certain offenders in custody of secretary of corrections or commissioner of juvenile justice authority. (a) If a corrections employee has been placed in contact with body fluid from one or more offenders while performing duties within the scope of such employee's duties as a corrections employee, the secretary of corrections or the secretary's designee or the commissioner of the juvenile justice authority or the commissioner's designee upon consultation with a medical care provider may make application to the district court of the county where the offender or offenders are in custody for an order requiring such offender or offenders to submit to tests for infectious diseases. Such application shall include an allegation that the offender or offenders sought to be tested have been requested to voluntarily submit to tests for a specific infectious disease or diseases and have refused the tests and that the corrections employee has agreed to voluntarily testing for the same infectious disease, including appropriate follow-up testing. When any such application is received, the court shall hold a hearing forthwith and shall issue its order thereon immediately if the court finds that: (1) There is probable cause to believe that the employee involved has been placed in contact with body fluid of the offender or offenders sought to be tested; and (2) the offender or offenders sought to be tested have been requested to submit to the tests and have refused, unless the court makes a further finding that exigent circumstances exist that would, in the court's judgment, excuse the applicant from making such a request. Expenses of the testing shall be assessed as a cost of the proceeding.

(b) If a test for an infectious disease ordered pursuant to this section results in a negative reaction, the court, upon proper application, shall order the offender tested to submit to another test six months after the date the first test was administered.

(c) If a test is ordered pursuant to this section, the corrections employee shall designate a health care provider or counselor to receive the test results on behalf of the corrections employee. The results of the test shall be disclosed to the court that ordered the test, the person tested and the health care provider or counselor designated by the corrections employee. The results shall also be disclosed to the secretary of corrections or the commissioner of the juvenile justice authority for inclusion in the offender's medical records. Test results of the corrections employee shall not be disclosed except as specifically authorized in writing by the employee.

(d) When a court orders an offender to submit to tests under this section which require withdrawal of blood, the withdrawal of the blood may be performed only by: (1) A physician or a person acting under the supervision of a physician; (2) a licensed professional nurse or a licensed practical nurse; or (3) a qualified medical technician. No person authorized by this subsection to withdraw blood, no person assisting in the performance of the tests nor any medical care facility where blood is withdrawn or tested that has been ordered by the court to withdraw or test blood shall be liable in any civil or criminal action when the act is performed in a reasonable manner according to generally accepted medical practices.

(e) The results of tests or reports, or information therein, obtained under this section shall be confidential and shall not be divulged to any person not authorized by law to receive such results, reports or information. Any violation of this subsection is a class C misdemeanor.

History: L. 1993, ch. 221, § 4; L. 2001, ch. 102, § 3; L. 2005, ch. 40, § 2; July 1.

65-6018. HIV screening for pregnant women and newborn children; rules and regulations. (a) A physician or other health care professional who is otherwise authorized by law to provide medical treatment to a pregnant woman shall take or cause to be taken, during the first trimester of pregnancy, a routine opt-out screening for HIV infection. When the physician or other health care professional determines certain pregnant women to be at high risk for acquiring HIV infection, such women shall be administered a repeat screening during the third trimester or at the time of labor and delivery. When a pregnant woman's HIV status is unknown for any reason at the time of labor and delivery, such woman shall be screened for HIV infection as soon as possible within medical standards. When an HIV rapid test kit is used for screening, a confirmatory sample shall be submitted for serological testing which meets the standards recognized by the United States public health service for the detection of HIV to a laboratory approved by the secretary of health and environment for such serological tests. A pregnant woman shall have the right to refuse screening under this subsection at any time. Before any screening is performed under this subsection, the pregnant woman shall be informed in writing of the provisions of this subsection and the purposes and benefits of the screening, and the pregnant woman shall sign a form provided by the department of health and environment to authorize or opt-out of the screening. The form shall contain the following wording: "I test all of my pregnant patients for HIV as part of the panel of routine tests to alert me to any conditions that can have a very serious effect on your pregnancy and your baby. You will be tested for HIV unless you tell me not to."

(b) When the mother's HIV status is unknown because of refusal to take such screening during the pregnancy or any other reasons, such mother's newborn child shall be screened with an HIV test as soon as possible within medical standards to determine if prophylaxis is needed. A mother's or a guardian's consent is not required to screen such newborn child, except that this subsection shall not apply to any newborn child whose parents object to the test as being in conflict with their religious tenets and practices. Documentation of a mother's HIV status shall be recorded in both the mother's and newborn's medical records. The mother of the child shall be informed in writing of the provisions of this subsection and of the purposes and benefits of the screening and shall sign a form stating that the mother has received the information.

(c) The secretary of health and environment is hereby authorized to adopt rules and regulations, within six months from the effective date of this section, establishing guidelines for routine HIV infection screening for pregnant women and each newborn child where the HIV status of the mother is unknown at the time of birth. These rules and regulations shall be based on the recommendations and best practices established by the United States centers for disease control and prevention and public health service task force recommendations for use of antiretroviral drugs in pregnant HIV infected women for maternal health and interventions to reduce perinatal HIV transmission in the United States.

(d) As used in this section, physician, HIV and HIV infection have the meanings defined in K.S.A. 65-6001, and amendment thereto.

(e) This section shall be effective on and after July 1, 2010.

History: L. 2010, ch. 118, § 1; Apr. 29.

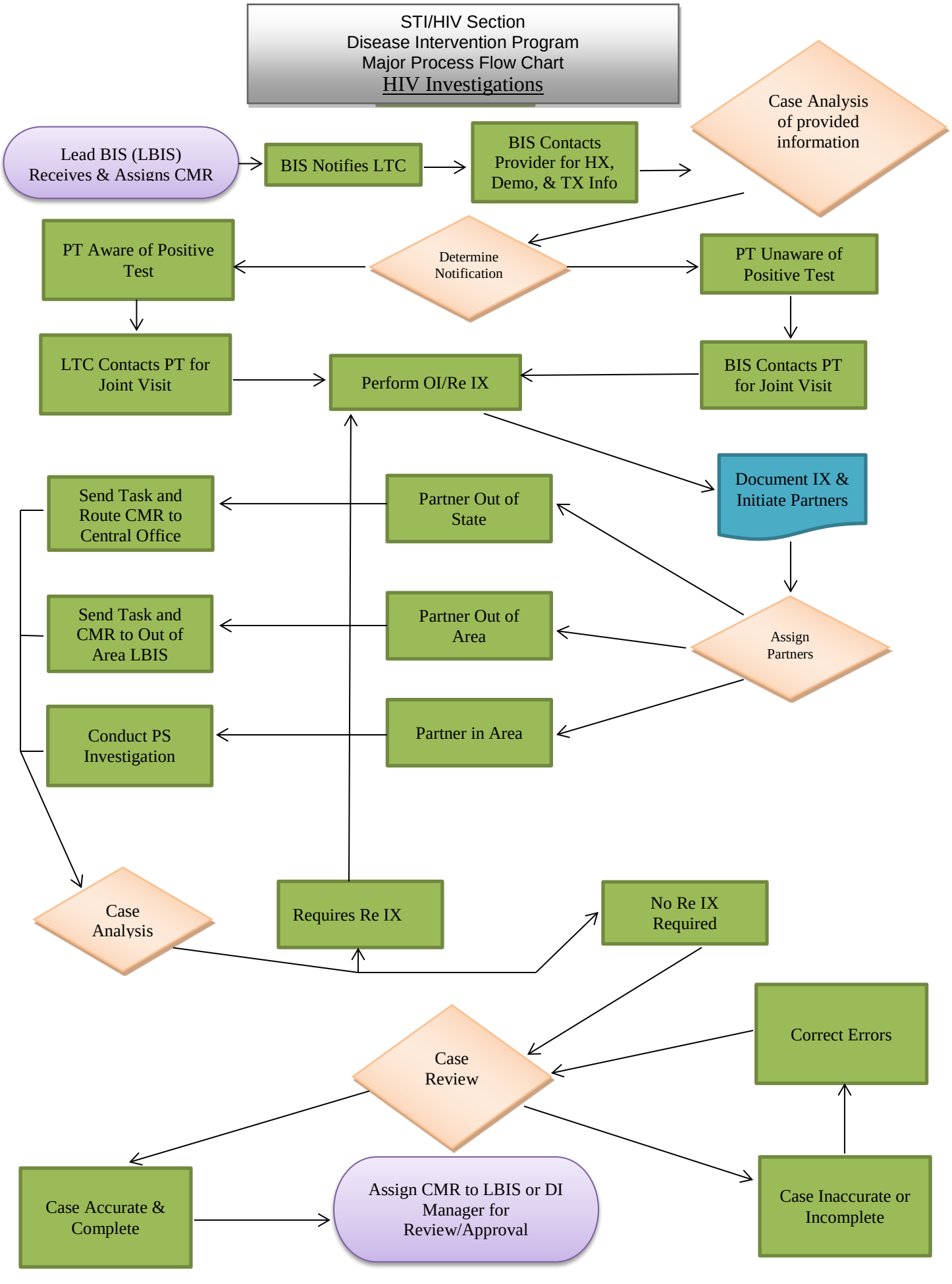
HIV/AIDS REGULATIONS

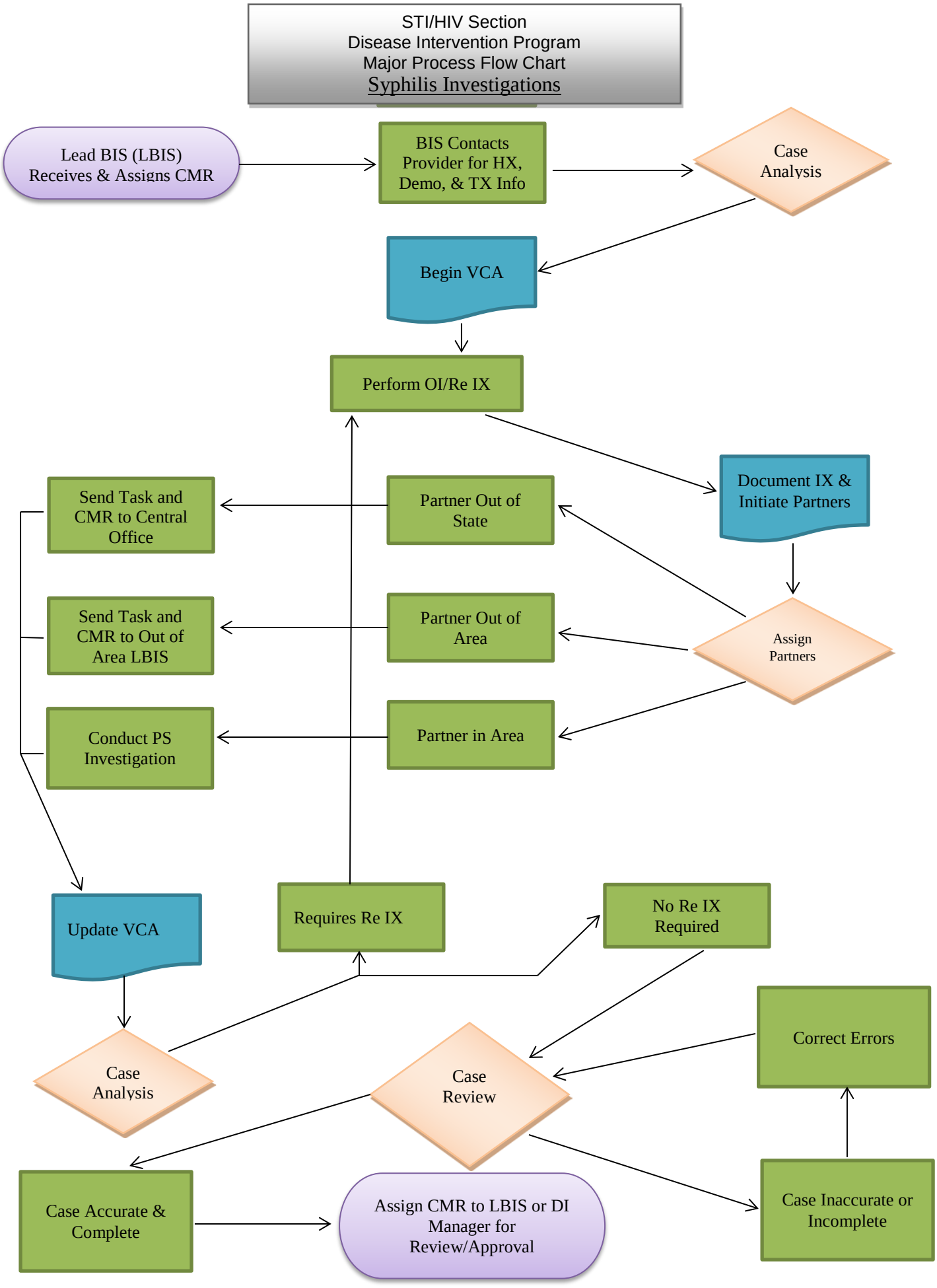
28-1-26 Protection of confidentiality of information regarding individuals with HIV infection.

(a) Definitions. Each of the following terms shall have the meaning specified in this subsection:
(1) “AIDS'' means the acquired immune deficiency syndrome.
(2) “Authorized personnel'' means individuals who have signed a confidentiality statement.
(3) “Confidentiality statement'' means a written statement, dated and signed by an applicable individual, that certifies the individual's agreement to abide by the security policy of a public health agency and this regulation.
(4) “Counseling and testing site'' means a site where counseling and testing for HIV infection are available.
(5) “HIV'' means the human immunodeficiency virus.
(6) “HIV confidential information'' means all combinations of individual data elements or information collected for surveillance purposes pursuant to K.S.A. 65-6002 and amendments thereto, in electronic or hard copy, that could identify anyone with HIV or AIDS, including the name, date of birth, address, and other identifying information.
(7) “HIV confidentiality officer'' means the official in a public health agency responsible for implementing and enforcing all the measures to protect HIV confidential information as defined under this regulation.
(8) “HIV infection'' means the presence of HIV in the body.
(9) “HIV prevention counseling'' and ``HPC'' mean a client-centered counseling activity designed to assist clients in assessing their risks of acquiring or transmitting HIV and in negotiating a realistic and incremental plan for reducing risk.
(10) “HIV report'' means a report of HIV infection or AIDS transmitted to a public health agency pursuant to K.S.A. 65-6002 and amendments thereto.
(11) “Partner counseling and referral services'' and ``PCRS'' mean a prevention and control activity conducted by trained individuals who contact and counsel each individual with HIV infection or AIDS who is reported to the secretary utilizing HPC.
(12) “Public health agency'' means any organization operated by any state or local government that acquires, uses, discloses, or stores HIV confidential information for public health purposes.
(13) “Secretary'' means the secretary of health and environment.
(14) “Secured area'' means the physical confinement limiting the location where HIV confidential information is available.
(15) “Written security policy'' means written specifications of the measures adopted to protect HIV confidential information and a description of how to implement these measures.
(b) Each public health agency shall appoint an HIV confidentiality officer, who shall have the authority to make decisions about the agency operations that could affect the protection of HIV confidential information.
(c) HIV confidential information shall be maintained in a secured area that is not easily accessible through a window and that is protected by a locked door. Access to the secured area shall be limited to authorized personnel only, and ``Restricted area—No unauthorized access'' signs shall be prominently posted. Access to the secured area by cleaning crews and other building maintenance personnel shall be granted only during hours when authorized personnel are available for escort or under conditions in which the data is protected by security measures specified in the written security policy. (d) Hard copy records containing HIV confidential information shall be kept in a locked cabinet located in a secured

area, except when in use by authorized personnel. Records shall not be removed from any secured area without authorization from the HIV confidentiality officer.
(e) All electronic records containing HIV confidential information shall be kept on computers protected by coded, individual passwords and located in a secured area. Each transfer of records onto removable electronic media shall occur only if absolutely necessary for HIV surveillance program operations and shall be required to be authorized by the HIV confidentiality officer. The records shall always be encrypted before the transfer to the removable media. Exchange of HIV confidential information using electronic mail shall be done only if encryption procedures are utilized.
(f) HIV confidential information shall be permanently removed from HIV records as soon as the information is no longer necessary for the purposes of the prevention and control of HIV infection.
(g) Mail containing HIV confidential information shall not include on the envelope or address any reference to the HIV infection, to the HIV virus, or to AIDS.
(h) All telephone conversations in which HIV confidential information is exchanged shall be conducted in a manner that prevents the conversations from being overheard by unauthorized persons.
(i) Each local health officer responsible for a public health agency shall adopt and implement a written security policy related to HIV confidential information consistent with the provisions of this regulation. A copy of the security policy shall be distributed to all authorized personnel.
(j) Access to HIV confidential information shall be restricted to a minimum number of authorized personnel trained in confidentiality procedures and aware of penalties for the unauthorized disclosure of HIV confidential information. The HIV confidentiality officer shall authorize the persons who may have access to HIV confidential information and shall keep a list of these authorized personnel.
(k) Each person authorized to access HIV confidential information shall sign a confidentiality agreement. The HIV confidentiality officer shall maintain a copy of the confidentiality agreement for all authorized personnel.
(l) HIV confidential information shall not be cross-matched with records in other databases if the resulting cross-matched databases do not have equivalent security and confidentiality protections, and penalties for unauthorized disclosure as those for the HIV confidential information.
(m) The use of records containing HIV confidential information for research purposes shall be required to be approved in advance by institutional review boards, and all researchers shall sign confidentiality statements. Information made available for epidemiologic analyses shall not include names or other HIV confidential information and shall not result in the direct or indirect identification of persons reported with HIV and AIDS.
(n) Authorized personnel designated by the secretary shall provide confidential, voluntary PCRS in accordance with this regulation. Any personnel providing PCRS who have reason to believe that a spouse, sex partner, or needle-sharing partner of a person who either is infected with HIV or has AIDS may be exposed to HIV or AIDS and is unaware of this risk of exposure may inform the spouse or partner of the risk of exposure if they do not reveal any identifying information about the original patient, including the name, physical description, time frame, method of transmission, and frequency of exposure.
(o) All communication between public health agencies, both interstate and intrastate, for the purpose of supporting surveillance and PCRS activities, shall disclose information only to the extent necessary to protect the public health pursuant to K.S.A. 65-6002 and amendments thereto.
(p) Each security breach of HIV confidential information shall be investigated by the HIV confidentiality officer, and personnel sanctions and criminal penalties shall be imposed as appropriate. The HIV confidentiality officer shall make an immediate telephone notification to the secretary that a breach of

HIV confidential information occurred and shall transmit to the secretary a written report within seven days from the time the breach is discovered.
(q) This regulation shall apply to the following:
(1) All public health agencies engaged in the provision of services to prevent and control HIV or AIDS as specified in K.S.A. 65-6003 and amendments thereto;
(2) all individuals required to send HIV reports to the secretary under K.S.A. 65-6002, and amendments thereto; and
(3) all counseling and testing sites that receive funds from public health agencies.
(Authorized by K.S.A. 65-101 and 65-6003; implementing K.S.A. 65-6002 and 65-6003; effective Feb. 18, 2000; amended July 7, 2006.)


STI/HIV Section
Disease Intervention Program
Major Process Flow Chart
HIV Investigations
Lead BIS (LBIS) Receives & Assigns CMR
BIS Notifies LTC
BIS Contacts Provider for HX, Demo, & TX Info
Case Analysis of provided information
PT Aware of Positive Test
Determine Notification
PT Unaware of Positive Test
LTC Contacts PT for Joint Visit
Perform OI/Re IX
BIS Contacts PT for Joint Visit
Document IX & Initiate Partners
Send Task and Route CMR to Central Office
Partner Out of State
Send Task and CMR to Out of Area LBIS
Partner Out of Area
Assign Partners
Conduct PS Investigation
Partner in Area
Case Analysis
Requires Re IX
No Re IX Required
Case Review
Correct Errors
Case Accurate & Complete
Assign CMR to LBIS or DI Manager for Review/Approval
Case Inaccurate or Incomplete


STI/HIV Section
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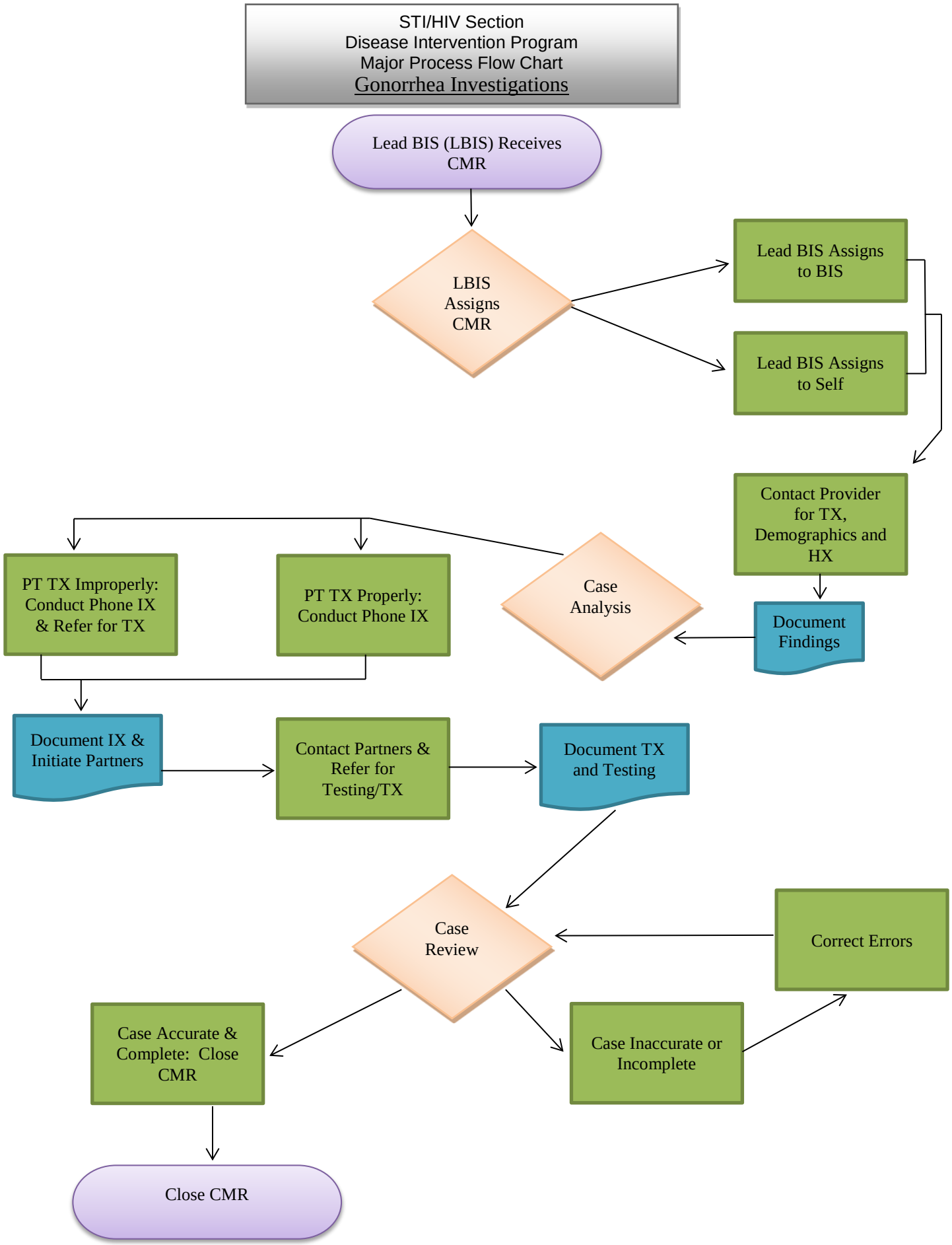
Syphilis Investigations
Lead BIS (LBIS) Receives & Assigns CMR
BIS Contacts Provider for HX, Demo, & TX Info
Case Analysis
Begin VCA
Perform OI/Re IX
Document IX & Initiate Partners
Partner Out of State
Send Task and CMR to Central Office
Partner Out of Area
Send Task and CMR to Out of Area LBIS
Assign Partners
Partner in Area
Conduct PS Investigation
Update VCA
Requires Re IX
No Re IX Required
Case Analysis
Case Review
Correct Errors
Case Accurate & Complete
Assign CMR to LBIS or DI Manager for Review/Approval
Case Inaccurate or Incomplete


STI/HIV Section
Disease Intervention Program
Major Process Flow Chart
Gonorrhea Investigations
Lead BIS (LBIS) Receives CMR
LBIS Assigns CMR
Lead BIS Assigns to BIS
Lead BIS Assigns to Self
Contact Provider for TX, Demographics and HX
Document Findings
Case Analysis
PT TX Improperly: Conduct Phone IX & Refer for TX
PT TX Properly: Conduct Phone IX
Document IX & Initiate Partners
Contact Partners & Refer for Testing/TX
Document TX and Testing
Case Review
Correct Errors
Case Accurate & Complete: Close CMR
Case Inaccurate or Incomplete
Close CMR